DT0030

CHILDREN'S OF ALABAMA
GA Imaging SCHEDULING (PRE-ADMISSION) FORM

TODAY'S DATE: 8/20/2015

(Please select facility for procedure) **Benjamin Russell---(FAX (205)638-5292)**

ALL PATIENTS HAVING MRI's or CT's WILL NEED TO BE PRE-SCREENED BY APASS (205) 638-6235
H&P MUST BE COMPLETED WITHIN 30 DAYS OF PROCEDURE DATE AND FAXED TO APASS 638-5242

This form can be used as the physician order IF this section is completed and signed by ordering physician.

Order (procedure): _____

Physician Name:_____ **Physician Signature:**_____ **Date:**_____ **Time:**_____

Patient's Legal Name: First: _____ **Middle:** _____ **Last:** _____

DOB: _____ **Sex:** Male **MR#** _____

Is this child a twin or multiple births? Single **Comments:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Parent/Guardian Legal Name: _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____**Email Address:** _____

Alternate Contact Name: _____ **Relationship:** _____ **Ph#:** _____

Allergies (Please List): _____ ☐ **No Known Drug Allergies**

☐ **Latex Allergy** ☐ **Latex Precaution** ☐ **No Latex Allergies**

Additional Patient Info _____(i.e. Hemophilia, Home Vent, DHR Custody, Sickle Cell, MH, TB)

Interpreter Needed: ☐ **Yes** ☐ **No** **Language:** _____

(If yes, please notify Patient Relations office at (205)638-9191 to schedule interpreter)

Select Test: ☐ **MRI** ☐ **CT** ☐ **PET** ☐ **SPECT** ☐ **MRA** ☐ **MRV**

If scheduling MRI, Does the patient have any of the following? Yes **Surgically implanted metallic devices**
Yes **Programmable Shunt** Yes **Cochlear Implant** Yes **Braces or Dental Implant** Yes **Vagal Nerve Stimulator**

Procedure: _____ ☐ **With Contrast** ☐ **Without Contrast** ☐ **With and Without Contrast**

Date for Test (list 2 date options): _____ (We will contact you with confirmed date)

Ordering Physician: _____ **Contact#:** _____ **Fax#:** _____

Primary Care Physician: _____ **Contact#:** _____ **Fax#:** _____

Admission Type: OP Admit Date: _____**Pre-Op Diagnosis:** _____**ICD-9/ICD-10 Code:** _____**CPT Code** _____

INSURANCE INFORMATION **(Attach Front and Back copy of Insurance cards)**

Primary Ins. Co: _____ **Ins Ph#:** _____

Subscriber's Name: _____ **Subscriber's DOB:** _____ **Relationship to Patient:** _____

Policy #: _____ **Group #:** _____ **Primary Pre-Cert # (Required):** _____

Who will complete History & Physical (H&P)? _____ **Date:** _____

Reason for Test: _____

Form filled out by:

Name: _____ **Signature:** _____ **Contact Phone #**_____**Contact Fax #**_____

(NOTE: After completing and printing a copy of this form, choose "Save As" and save that file with another name, so you will have this blank copy for next time.)

For Office Use Only:

Scheduled by_____ **Date**_____**ECD#**_____ **CCN**_____

11/2013 JBD