RADIOLOGY SCHEDULING FORM

OFFICE #: (818) 902-5737 or FAX #: (818) 902-5139

Date of Procedure: _____ Requested Time: _____ Length: _____

Last Name: _____ First Name: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female Social Security #: _____

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Allergies: _____ HT _____ WT _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number (Primary): _____ Alternate Phone: _____

Parent/Guardian/Facility Name: _____

Surgeon: _____ Request Assistant: □ Yes □ No: _____

Diagnosis: _____

ICD-10: _____ CPT Code: _____

Procedure:

_____

Anesthesia Type: ☐ MAC ☐ Moderate Sedation ☐ Other: _____

Co-morbidities: (Select all that apply) ☐ None ☐ Cardiac/Vascular Disease/Hypertension

☐ Endocrine/Diabetes/Thyroid Disease ☐ Respiratory Disease (Smoker/Sleep Apnea) ☐ Kidney Disease

☐ Liver Disease ☐ Neurologic Disease ☐ Hematologic/Bleeding Disorders

Insurance Name: _____ Policy Number: _____

Insurance Type: ☐ HMO ☐ PPO ☐ MediCare ☐ MediCal

If HMO IPA Name: _____ Days Approved: _____

Authorization Number: _____ ☐ N/A Exp. Date: _____

Special Equipment (Implants/Hardware): ☐ NONE _____

Vendor/Rep ☐ None _____ Tel: _____ E-mail: _____

****PLEASE ATTACH A COPY OF AUTHORIZATION, IDENTIFICATION CARD, COPY OF INSURANCE CARD(S) (Front & Back) H&P (within 30 days), ORDERS and LABS (within 30 days).**

VALLEY PRESBYTERIAN HOSPITAL