Bellevue Medical Imaging, PLLC

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Office Hours: M-F 7am-7pm

www.bmirad.com

See exam preparations, map and directions on back

Patient Name:_____ **DOB**:_____ **Phone #:**_____
Ins. Provider: _____ **Ins. Member #:** _____ **Precert/Auth #:** _____
Referring Physician:_____ **Phone #:**_____ **Fax #:** _____

Physician Signature: _____ **Date:** _____

☐ **BMI to call patient to schedule** ☐ **Patient will call to schedule** ☐ **Send CD W/ Pt.** ☐ **Send CD to Office**
☐ **Routine** ☐ **Stat** ☐ **Stat Call Report # (_____)_____** ☐ **Stat Fax Report**

Contrast Allergies ☐ **Yes** ☐ **No** **Pregnant** ☐ **Yes** ☐ **No** **Breast Feeding** ☐ **Yes** ☐ **No**

Clinical Signs or Symptoms (REQUIRED): _____
_____

PRIOR RELEVANT IMAGING STUDIES:
Study: _____ Facility: _____ Exam Date: _____

MRI ☐ **W/O Contrast** ☐ **W/ Contrast** ☐ **Contrast** (Per Radiologist Discretion) ☐ **Angio** ☐ **Arthrogram**
☐ Brain_____ ☐ Abdomen_____ ☐ Spine_____
☐ Extremity_____ ☐ Pelvis_____ ☐ Breast_____
☐ Other_____

CT ☐ **W/O Contrast** ☐ **W/ Contrast** ☐ **Contrast** (Per Radiologist Discretion) ☐ **Angio**
☐ Brain_____ ☐ Chest_____ ☐ Spine_____
☐ Abd/Pelvis_____ ☐ Sinus_____ ☐ Cardiac Score_____
☐ Soft Tissue Neck_____ ☐ Other_____

Ultrasound ☐ Breast_____ ☐ Head/Neck_____
☐ Abdomen Complete_____ ☐ Abdomen Limited_____ ☐ Pelvic (female)_____
(Liver, Gallbladder, Pancreas, Spleen, Kidney) (Hernia, Groin/Inguinal pain, Appendicitis) (Uterus/Ovaries, Irregular Bleeding, Pelvic Pain)
☐ Retroperitoneal_____ ☐ Extremity_____ ☐ OB_____
(Kidneys, Bladder, Prostate) LMP_____ DUE DATE_____
☐ Other_____

Mammography
☐ Screening W/ Ultrasound if indicated or requested by patient. ☐ Diagnostic W/ Ultrasound_____
☐ Screening Mammogram Only_____ (**If patient has symptoms diagnostic exam is required)**
****Pt will be recalled if further imaging is recommended**

X-Ray
☐ Spine_____
☐ Chest_____
☐ Other_____
Right **Left** **Bilateral**

Fluoro
☐ UGI_____
☐ Esophagram/Ba Swallow_____
☐ Other_____

DEXA
☐ DEXA_____

OTHER EXAM_____
_____