DIAGNOSTIC IMAGING REFERRAL

PATIENT INFORMATION

Patient Name: ____ DOB: _________________________

Address: ____

Cell Phone: ___________________________________ Home Phone: ______________________________

EXAM

Exam Requested 1: ____

Indication/Diagnosis: ____

Patient History: ____**ICD 10**: ________________

Exam Requested 2: ____

Indication/Diagnosis: ____

Patient History: ____**ICD 10**: ________________

☐ **Radiologist may modify the order per protocol to meet clinical needs of the patient.**

INSURANCE INFORMATION

Insurance Carrier: ____ ID: ______________________

Phone Number: ____Pre-Auth#: _________________________

For more accurate processing please attach a copy of the insurance card front and back to this order.

PROVIDER

Ordering Provider: _______________________________**Provider Signature:** ________________________

Date/Time Order Completed: __________________________

CC of Report to: ____

Provider Contact Information:

Phone: ____________________________________ Fax: _____________________________________

APPOINTMENT INFORMATION

Appointment Date/Time: ____ ☐ Patient Notified

Please fax completed referral to Compass Peak Imaging **844-684-4238**

This document contains confidential patient information. Please notify us immediately if you are not the intended recipient.