COMPASS PEAK IMAGING
MRI • CT • ULTRASOUND • XRAY

120 MIDLAND AVE, SUITE 260
GLENWOOD SPRINGS, CO 81601
PHONE: (970) 665-2194
FAX: (844) 684-4238

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: _____ Member 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: _____

Provider Phone #: _____ Provider Fax #: _____

Date/Time Order Completed: _____ CC of Report to: _____

APPOINTMENT INFORMATION

Appointment Date/Time (if known): _____ ☐ Patient Notified

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