CMI
CASCADE
MEDICAL IMAGING

Please fill this form out completely, attaching any insurance pre authorizations and pertinent chart notes. Fax all information to us at (541) 382-6635 so we may start the scheduling process for your patient. Please allow up to two weeks for a patient appointment to be scheduled. We will contact the patient to schedule their appointment, and contact you at the number you provide to inform you of the scheduled date and time. PET scans are done every Monday Wednesday and Friday mornings at Central Oregon Radiology Assoc., P.C./ Cascade Medical Imaging, LLC. Thank you for your referral.

PET EXAM TO BE SCHEDULED (please check one): ☐ SKULL BASE TO MID THIGH ☐ WHOLE BODY ☐ PET CARDIAC ☐ BRAIN ONLY ☐ LIMITED ☐ THYROGENASSISTED

PATIENT INFORMATION

Pt Name:_____ D.O.B._____/_____/_____ Age:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Patient Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

Patient Weight:_____ Height:_____ ☐ Male ☐ Female SS# : _____-_____-_____

Primary Insurance:_____ Secondary Insurance:_____

PLEASE PROVIDE US WITH A COPY OF THE PATIENT'S INSURANCE CARD (Front and Back)

Ref. Phy. Signature:_____ **Print** Ref. Phy Name:_____

Referring Physician Phone (____)_____ Referring Physician Fax: (____)_____

Please send a CC of the results to:_____

Does the Patient Have any Special Needs (e.g., deaf, blind, interpreter)? ☐ Yes ☐ No

If Yes What are they?_____

CLINICAL INFORMATION

Diagnosis:_____ ICD9 code(s):_____

Clinical Indication/Questions to be Answered:_____

_____

If Pre-Authorization is denied by the Patients' Insurance Company, what other course of action will you take? _____

_____ **Is the Patient Diabetic?** ☐ **Yes** ☐ **No**

If Yes, how its controlled? ☐ **Diet** ☐ **Oral Meds** ☐ **Insulin** **Blood Sugar Level:**_____

SUPPORT DOCUMENTATION

A COPY of the H & P and CHART NOTES are REQUIRED.

PERTINENT PREVIOUS EXAMS

	Date	Location Performed		Date	Location Performed
Nuc Med	_____/_____/_____	_____	MRI	_____/_____/_____	_____
CT	_____/_____/_____	_____	Op & Path (Lung Only)	_____/_____/_____	_____

For CMI Use Only:

Date Scheduled:_____/_____/_____ By:_____ Appointment Date:_____/_____/_____ Time:_____:_____

☐Patient Info. Sent: ☐ Referring Office Informed of Appointment: Auth#:_____

pet exam to be scheduled 7-18 cdd