

Patient Information:Last: _____ First: _____ Middle: _____
DOB: ___/___/___ Gender: _____**Parent/Guardian Information:** Last: _____ First: _____Email: _____ Preferred Phone: _____ Alt Phone: _____
Relationship: _____ Preferred Language (if not English): _____**Diagnostic Testing** -Ray(s): _____

_____ roscopy: _____

_____ exa Scan _____

_____***Requires Prior Authorization prior to referral**Prior Authorization #: _____

_____ CT*: _____ with contrast without contrast
_____ with contrast without contrast MRI*: _____ without contrast w/ & w/ out contrast
_____ without contrast w/ & w/ out contrast*For MRI only: Is there metal in the patient's body or an implanted device?* No Yes: _____ ar Medicine* _____

_____**Diagnostic Testing Urgency:** Urgent Routine**Preferred Location (if available):****Missouri:** Independence Kansas City Northland (KC)**Kansas:** Overland Park**Referring Provider Name:** _____ NPI (if new referring provider): _____**Practice Name:** _____ Call with acute findings only: Yes No**Office Phone:** _____ **Office Fax:** _____Primary Care Provider: Same as above Name: _____**Signature:** _____**Date:** _____