OUTPATIENTRADIOLOGY

Focused on Care, Driven by Excellence

Scheduling Eligibility Questionnaire

Patient Information: Name: ______________________ MI: ____ Exam Date: ________ Time: ________

Procedure: ______________________________ Doctor: ______________________

Reason for Exam: ______________________________ CC: ______________

Mailing Address: ____

Physical Address: ____

Phone: (H) ______________ (W) ______________ (C) ______________ DOB: ______________

Ht: ________ Wt: ________ Marital Status: M S W D Sep SSN: ______________ M / F

Patient's Employer: ____

Spouse/Responsible Party: ____

Responsible Party DOB: ______________________ Responsible Party SSN: ______________

Responsible Party Employer: ____

Insurance Information: Medicare #: ______________________ Medicaid #: ______________________

Insurance Carrier: ______________________________ Pre-cert required? Yes / No

Subscriber: ______________ ID #: ______________ Group: ______________

Deductible/Co-Insurance: ____

Claims Address: ____

Other Insurance: ____

Subscriber: ______________ ID #: ______________ Group: ______________

Deductible/Co-Insurance: ____

Claims Address: ____

Worker's Comp: CS # ______________ Injury Date: ______________ Employer: ______________

Other Studies: ____

Medical Background:

Pacemaker, CAGB, or stent?	Yes	No
Ever had brain surgery? Aneurysm?	Yes	No
Inner ear prosthesis (i.e. coclear implant)?	Yes	No
History of back surgery? Level ________	Yes	No
History of renal disease, diabetes, DOB ≥ 1950?	Yes	No
Creatinine level needed? Level: ________	Yes	No
Does the patient have hx of CA?	Yes	No
Shrapnel/metal fragments?	Yes	No
Ever had metal in their eyes?	Yes	No
History of MRSA?	Yes	No
Claustrophobic?	Yes	No
History of Seizures? Last seizure ________	Yes	No
Possible pregnancy?	Yes	No
Permanent eyeliner?	Yes	No
Dentures?	Yes	No
Is the patient wheelchair bound?	Yes	No
Is the patient **unable** to communicate?	Yes	No
Implanted devices? Neurostimulators?	Yes	No

Breast MRI:

First day of last period? ______________

Hormone treatment therapy? ______________

ANESTHESIA Patients:

- Fax OR scheduling sheet to 577-2239.
- Give technologist checklist.
- Remind ordering physician an EKG will be needed for patients over 50.
- H&P must be completed within 24 hrs of MRI
- Notify output floor of exam
  - Adult sedation: 577-7810
  - PEDS sedation: 577-2386
- OPR admits/recent Dr. notes

Outpatient Radiology: 307.232.5012

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