

Options to Schedule Imaging Procedures:

1. Go green and eliminate paper! Sign up for OHLink. Call (614) 544-eDoc (3362) to get started.
2. **Call** Central Scheduling at (614) 566-1111 or (877) 566-1112 and fax prescription to (614) 533-1111.
3. **Fax** this form to Central Scheduling at (614) 533-1111 and a scheduler will call the patient to schedule an appointment.

* = Required for legal script

Stat Read Please call patient and schedule. Patient not scheduled. Patient to walk-in.

Patient Information:

* **Date:** _____ **Requested Facility:** _____

* **Name:** _____ **DOB:** _____ **Sex:** M F

Patient Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Best Phone to Reach Patient: _____ **Alternate Phone:** _____

Interpreter: Yes No **Preferred Language:** _____

Procedure Information:

- | | | | |
|-----------------------------------|---|---|--|
| <input type="checkbox"/> MRI | <input type="checkbox"/> Diagnostic X-Ray | <input type="checkbox"/> Nuclear Medicine | <input type="checkbox"/> With Contrast |
| <input type="checkbox"/> MRA | <input type="checkbox"/> Bone Density | <input type="checkbox"/> Interventional Radiology | <input type="checkbox"/> Without Contrast |
| <input type="checkbox"/> CT | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Screening Mammography | <input type="checkbox"/> With/Without Contrast |
| <input type="checkbox"/> CT Angio | <input type="checkbox"/> Fluoroscopy | <input type="checkbox"/> Diagnostic Mammography | <input type="checkbox"/> Per Radiologist Protocol |

* **Procedure:** _____ **CPT Code:** _____

Example: MRI Foot Left

* **Diagnosis/Symptoms:** _____ **ICD 10(s):** _____

Special Instructions: _____

Ordering Physician Print Name: _____ ***Physician Signature:** _____

Physician Practice Tax ID #: _____ **Telephone:** _____

Fax: _____ **Office Contact:** _____

Please attach a copy of the patient demographic information, insurance card (front and back), verification information, imaging results, office notes, C-9 approval (if applicable), and any other pertinent clinical information.

MRI, CT and Nuclear Medicine Stress Test Clinical Information for Pre-certification Assistance

To enable us to assist you in meeting necessary pre-certification requirements, please complete the following:

How did the symptoms start? _____ When did they start? _____ How long? _____

MVA: Yes No | **STAT:** Yes* No | ***provider office to initiate due to timing** | BWC: Yes No

Any surgeries related to condition: Yes No | If Yes, Type: _____

Other diagnostic test done: Yes No | If Yes, Type: _____

Has the patient had any therapy? Yes No | **Did it help?** Yes No | **Type and Duration:** _____

Medications for this condition? Yes No | **Did it help?** Yes No | **Name and Duration:** _____

What is the primary question to be answered by doing this procedure? (rule out) _____

Other pertinent information that would support having a MRI, CT or NM Stress Test _____

Results of imaging procedures are made available to the patient through OhioHealth MyChart. The release will occur immediately, unless otherwise requested by the provider, in which case release will occur after 7 days. To request the result not be immediately released, the provider must indicate one of the following:

Immediate release of this result may risk the individual's life or physical safety.

Patient/Proxy specifically declined immediate release of this result.

Results not immediately released will be released to the patient's MyChart after 7 days.

Signed: _____ **Date:** _____

