



Advanced Medical Imaging

Bozeman Deaconess Hospital & Intercity Radiology
905 Highland Blvd., Suite 4100 - Bozeman, MT 59715
Phone: (406) 414-5200 Fax: (406) 414-5205

Appointment Scheduling
Scheduling (Radiology): (406) 414-5201
Fax (Film Library): (406) 414-1657

Patient Name: _____ Date of Birth: _____ [] Male [] Female

Patient Phone #: _____

Ref. Physician Name: _____

Ref. Physician Phone # : _____ Ref. Physician Signature: _____

Requested Appointment Date: _____ Time: _____

Does patient have Contrast Allergies? [] Yes [] No Previous Pertinent Studies: _____

ICD-10 Code: _____ Diagnosis/History/Symptoms: _____

Reports: [] Routine [] Call Report (must include phone number): _____ [] Special Request: _____

ATTENTION DOCTOR'S OFFICE STAFF: Pre-Approval may be required for some CT procedures. Please call insurance carrier to verify.

[] Pre-Approval was required for this procedure. (Please Initial: _____) Authorization #: _____

[] Pre-Approval was not required for this procedure. (Please Initial: _____)

CT

(unless otherwise specified, need for contrast & reconstruction determined by radiologist)

- [] IV Contrast per protocol
[] No IV Contrast

Is there any chance the patient could be pregnant?
[] Yes
[] No

- [] Head
[] Neck (soft tissue)
[] Paranasal Sinuses [] Stereo Sinuses
[] Temporal Bones
[] Chest
[] Low Dose Chest CT, screening for lung cancer
[] Abdomen (may require oral contrast)
[] Pelvis (may require oral contrast)
[] CT IVP (Abd/Pelvis with and without IV contrast)
[] Stone Survey (Abd/Pelvis without IV contrast)
[] C-Spine: _____
[] T-Spine: _____
[] L-Spine: _____
[] Extremity: _____ [] R [] L
[] CT Angiogram: _____
[] Other CT: _____

Glucophage [] Yes [] No
Is patient diabetic? [] Yes [] No
BUN: _____ Creatinine: _____
Date Drawn: _____
Special instructions: _____

GENERAL INSTRUCTIONS/SUGGESTIONS

- Please arrive fifteen minutes before your scheduled appointment.
- Please bring photo I.D., insurance information, referral request, and insurance authorization with you.

CT SCAN:

CT exams with oral contrast: Nothing to **EAT** or **DRINK** after midnight. If you must take medication, take it with a small drink of water or a small drink of contrast. Drink the entire first bottle 45 minutes prior to bedtime the night before the exam, ½ of the 2nd bottle 2 hours prior to the exam and the last ½ of contrast 1 hour prior to the exam. The contrast may be picked up at Advanced Medical Imaging or at Bozeman Deaconess Hospital Radiology.

If you have any questions or concerns, please call (406) 414-5200 and ask for CT.

CT exams with IV contrast only: No solid food 2 hours prior to the exam.

BUN/Creatinine lab test requirements: BUN and Creatinine tests are required when IV contrast is used in patients with the following:

1. 50 years of age and over
2. Single kidney
3. Diabetic
4. History of Renal insufficiency
5. Lab results must be within the last 4 weeks

