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 MRI 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: ____)

MRI

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

☐ Contrast per protocol

☐ No Contrast

Is there any chance the patient could be pregnant?

☐ Yes

☐ No

☐ Brain

☐ Neck (soft tissue)

☐ Chest

☐ Abdomen

☐ Pelvis

☐ Soft ☐ Boney

☐ MRCP

☐ C-Spine: _____

☐ T-Spine: _____

☐ L-Spine: _____

☐ Hip ☐ R ☐ L

☐ Knee ☐ R ☐ L

☐ Shoulder ☐ R ☐ L

☐ Extremity: _____ ☐ R ☐ L

☐ MR Angiogram: _____

☐ Other MRI: _____

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.**

MRI: You will be asked to complete this screening form when you arrive. Some metal objects, such a pacemaker or implanted devices may prohibit you from having an MRI. Please contact us if you have any questions or concerns: (406) 414-5200.

Do You Have:

1. Pacemaker	☐ **Yes**	☐ **No**
2. Brain Surgery or Brain Aneurysm Surgery	☐ **Yes**	☐ **No**
3. History of Metal in Eyes (From welding, grinding)	☐ **Yes**	☐ **No**
4. Are you currently on dialysis?	☐ **Yes**	☐ **No**
5. Bone Stimulator, Neurostimulator, Biostimulator	☐ **Yes**	☐ **No**
6. Implanted Electrical Devices	☐ **Yes**	☐ **No**
7. History of Gunshot Wound or Shrapnel	☐ **Yes**	☐ **No**
8. Joint or Limb Replacement Surgery	☐ **Yes**	☐ **No**
9. IVC Filter *(Inferior Vena Cava)*	☐ **Yes**	☐ **No**
10. Ear Surgery ***(What type**:_____)*	☐ **Yes**	☐ **No**
11. Orbit Prosthesis	☐ **Yes**	☐ **No**
12. Heart Surgery: ***Open*** or ***Stent*** *(Date of Surgery: ____/____/____).*	☐ **Yes**	☐ **No**
13. Heart Valve Surgery	☐ **Yes**	☐ **No**
14. History of Cardiac Arrhythmias or Seizures	☐ **Yes**	☐ **No**
15. Known or Possible Pregnancy	☐ **Yes**	☐ **No**
16. IUD (Intra Uterine Device)	☐ **Yes**	☐ **No**
17. Hearing Aid, Dentures, Removable Dental Work	☐ **Yes**	☐ **No**