



Ph: (860) 585-3020
Fax: (860) 585-3743 Centralized Scheduling Department

DIAGNOSTIC SERVICES REQUEST FORM

Appointment Date \_\_\_\_\_
Time \_\_\_\_\_
Special Instructions \_\_\_\_\_

TODAYS DATE \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ DOB \_\_\_\_\_ SEX  M  F

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_ HOME PHONE \_\_\_\_\_ CELL # \_\_\_\_\_

PRIMARY INSURANCE/ID # \_\_\_\_\_ SECONDARY INSURANCE/ID# \_\_\_\_\_

AUTHORIZATION #'s \_\_\_\_\_

ORDERING M.D. \_\_\_\_\_ COPY TO M.D. \_\_\_\_\_ COPY TO M.D. \_\_\_\_\_

RADIOLOGY

- Abdomen  Chest
 Extremity (Specify) \_\_\_\_\_
 Hip (Specify) \_\_\_\_\_
 Pelvis  IVP
 Spine (Specify) \_\_\_\_\_
 Barium Enema  with air
 Barium Swallow  with speech
 GI's  Small Bowel Series
 Other \_\_\_\_\_
 Contrast Allergy \_\_\_\_\_
 EEG

ULTRASOUND

- Abdomen (Specify) \_\_\_\_\_
 Amniocentesis
 Aorta
 Breast (Specify) \_\_\_\_\_
 Carotid Artery
 Leg (Specify) \_\_\_\_\_
 Pelvis /Transvaginal if Necessary
 Pregnancy/ wks. \_\_\_\_\_
 Renal
 Thyroid
 Other \_\_\_\_\_

CT SCAN

- Abdomen  Abdomen/Pelvis  Chest
 Pelvis  Head  Cervical  Lumbar
 Extremity with 3D reconstruction if needed
 Other \_\_\_\_\_
\*Contrast  with  without  with & w/out
 Diabetic  Contrast Allergy \_\_\_\_\_

NUCLEAR MEDICINE

- Bone Scan (Specify) \_\_\_\_\_
 Gastric Emptying
 HIDA Scan  MUGA
 Thyroid Scan  Thyroid Uptake
 VQ Lung Scan
 PET Scan  Diabetic
 Other \_\_\_\_\_

Patients weight \_\_\_\_\_

Cardiolite Stress

Persantine Stress

CARDIO-PULMONARY

- Stress  Echo  EKG
 Holtor Monitor
 Pulmonary Function Test  with ABG's
 Vascular Arterial Study \_\_\_\_\_
 Other \_\_\_\_\_

MRI

- Abdomen  Brain  Pelvis
 Breast (Specify) \_\_\_\_\_
 Extremity (Specify) \_\_\_\_\_
 Hip (Specify) \_\_\_\_\_
 Cervical  Lumbar  Thoracic Spine
Other \_\_\_\_\_

\*Contrast  with  with out  with & w/out

\*MRA

- Abdomen  Brain  Carotid Artery
 Extremity (Specify) \_\_\_\_\_  Bilateral
 Renal  Other \_\_\_\_\_
 with 3D reconstruction if needed
 Diabetic  Contrast Allergy \_\_\_\_\_

\*Lab work required on all patients:
•Age 60 or above •Diabetic
•Gout/Hyperuricemia •Hypertension
•Pre-existing kidney disease or surgery
 BUN \_\_\_\_\_
 CREATININE \_\_\_\_\_

Diagnosis, Svmptoms, and/or History

Physician's Signature \_\_\_\_\_

Centralized Scheduling Instructions:

Routine: Call 860-585-3020
Mon-Wed 8am-6pm Thurs 8am-7pm Fri 8am-5:30pm
After Hours: Fax completed Fax Order to 860-585-3743
STAT: Call Centralized Scheduling 860-585-3020

Patients should call 3 days before appointment to pre-register 860-585-3786
Hours to call: Mon-Thurs 8:30am-7:30pm

BEEKLEY CENTER SERVICES

MAMMOGRAPHY

- Screening w/ US for dense breast tissue > 50 %
 Diagnostic w/ US for dense breast tissue > 50%
 Unilateral (R) (L) w/ US for dense breast tissue > 50%

Previous BH BRC OTHER Date \_\_\_\_\_

DENSITOMETRY

Bone Density Scan: \_\_\_\_\_

Previous BH BRC OTHER Date \_\_\_\_\_

ULTRASOUND

Breast (Specify) (R) (L) BILAT \_\_\_\_\_

BREAST BIOPSIES

L or  R Breast Ultrasound Guided Biopsy

L or  R Breast Stereotactic Mammogram Guided Biopsy