Hilo Benioff Medical Center
Hilo Benioff Medical Center: East Hawaii Region, Hawaii Health Systems Corporation
1190 Waianuenue Avenue, Hilo, Hawaii 96720

# DIAGNOSTIC IMAGING ORDER REQUISITION

**IMAGING DEPARTMENT**

Phone Number: (808) 932-3800 | Fax Number: (808) 932-2502

## PATIENT DEMOGRAPHICS

| LAST NAME | FIRST NAME | MIDDLE INITIAL | BIRTHDATE | AGE |
|---|---|---|---|---|
| | | | | |

| ADDRESS | | | SEX: M / F | LAST PERIOD? |
|---|---|---|---|---|
| | | | | |

| CITY | STATE | ZIP | PHONE NUMBER | WEIGHT (LBS) | PREGNANT: YES / NO |
|---|---|---|---|---|---|
| | | | | | |

## PATIENT INSURANCE INFORMATION

| | | | |
|---|---|---|---|
| **Primary Insurance:** | | Pre-Approval: ☐ Yes ☐ Pending | |
| **Member Number:** | | ****Hard copy of prior authorization required before scheduling.**** | |
| Secondary Insurance: | | W/C: ☐ No-Fault: ☐ | Date of Injury: |
| Member Number: | | Auth/Claim #: | Adjuster Info: |

## DIAGNOSIS

WRITTEN DIAGNOSIS:

ICD 10 Code(s):

## PROCEDURES

CPT Codes:

☐ ROUTINE ☐ URGENT (48 HOURS) ☐ STAT (24-48 Hours)

| FAX PRELIM REPORT TO FAX #: | FAX FINAL REPORT TO FAX #: | CALL PRELIM REPORT TO (Dr. / PHONE #) |
|---|---|---|
| | | |

Cc REPORT TO: SEND IMAGES TO:

☐ **CT** ☐ **CTA** ☐ **MRI** ☐ **MRA** ☐ **NM** ☐ **ULTRASOUND** ☐ **XRAY** ☐ **SPECIAL PROCEDURES**

| EXAM 1: | EXAM 3: |
|---|---|
| EXAM 2: | PREP: |

## APPROPRIATE USE CRITERIA (AUC) Required for CT, CTA, MRI, MRA, NM

**Vendor:**

| **ID Number:** | **Appropriateness:** |
|---|---|

| **APPOINTMENT INFORMATION** *To be completed by Imaging staff* | | **NOTES** |
|---|---|---|
| Appointment Date: | | |
| Appointment Time: | | |
| Check-In Time: | | |

## SURGICAL & IMAGING HISTORY

Surgery in area of scan? ☐ NO ☐ YES If yes, what type and when?

Comparison Studies: ☐ NO ☐ YES If yes, please check: ☐ MRI ☐ CT ☐ X-RAY ☐ US ☐ NM

Location and Date of Previous Studies, if known:

Previous films and reports will be transported to HMC BY: ☐ Courier ☐ Mail ☐ Patient

Known Allergies:

| **PRE-SCREENING FOR CT** | **PRE-SCREENING FOR MRI** Please do not fax unless the information below is completed | | |
|---|---|---|---|
| History of renal disease? ☐ NO ☐ YES | Cardiac Pacemaker or ICD | ☐ NO | ☐ YES |
| If the patient is on dialysis, what is their dialysis schedule? Day: Time: | Biostimulator Implant | ☐ NO | ☐ YES |
| History of Liver Disease? ☐ NO ☐ YES | Claustrophobic | ☐ NO | ☐ YES |
| | Aneurysm Surgery | ☐ NO | ☐ YES |
| Hx of allergic reaction to IV contrast dye? ☐ NO ☐ YES | History of Cancer | ☐ NO | ☐ YES |
| | History of Foreign Body in EYES | ☐ NO | ☐ YES |

**Signature** _____ **Date:** **Ordering Provider's Printed Name:**