DERRY IMAGING

Overlook Medical Park
6 Tsienneto Road, Suite LL100
Derry, NH 03038

MRI/CT Scheduling:
603-537-1378
603-537-1394
MRI/CT Fax: 603-434-3749

EXAM: ❑ MRI ❑ CT

PATIENT INFORMATION

Date/Time of Exam: _____ Date of Birth: _____

Patient Name: _____

Phone:_____ Work Phone: _____

INSURANCE INFORMATION

Insurance Carrier: _____ Group/Policy: _____

Policy Holder/DOB: _____ Precert#/Exp Date: _____

Name of Authorization Rep: _____

SCAN INFORMATION

Referring Physician: _____ PCP: _____

Physician Phone: _____ Fax: _____

Area to be scanned: _____ Prior Surgery to areas: YES NO

PRIOR STUDIES TO AREA BEING SCANNED: YES NO / WHERE: _____ WHEN: _____

PRIORS–PLEASE HAVE PATIENT BRING CD OF PRIOR IMAGES ON DAY OF EXAM.

Primary Diagnosis: _____

_____

Signs & Symptoms: _____

(A "rule out" diagnosis may accompany a diagnosis for signs and symptoms but is not acceptable by itself)

If CONTRAST is required: Patients who are over 60, diabetic, or have high blood pressure labs (bun/creat) are required and must be done within 30 days of exam.

WARNING!! AN MRI CANNOT BE PERFORMED IF A PATIENT HAS ANY OF THE FOLLOWING:

Pacemaker or Pacemaker wires – Defibrillator Device – Cochlear Implant – Small Bowel Endoscopy Capsule

Check if applicable:

❑ Metal in body including eyes ❑ Prior contrast reaction ❑ Claustrophobic ❑ Weighing over 300 lbs.

PHYSICAN'S SIGNATURE: DATE:

_____ _____