

## **Emory Department of Radiology & Imaging Sciences** Radiology Procedure Scheduling

Phone: 404-712-0566 Fax: 404-712-7122
Office Hours 7:30am-5pm,Monday-Frida

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Medical Record Number	Required information needed to schedule:
Patient Name (Last Name, First Name MI):	Attending MD Name
	UPIN #* Office Phone
	FaxPIC:
Date of Birth	Patient's Phone (H/W/Cell)
HeightWeight	
Insurance Plan/FSC:	Office contact person:
Member Insurance#	i
	Email
* <u>UPIN</u> needed for physicians. † <u>Referral #</u> : Provide PCP to Specialist referral #	Email:
ICD-9 Codes:	
Diagnosis/Indications:	
Urgency: □ Stat □ Routine* Reque	ested Clinic / Procedure Date:
□ Biopsy:	Radiology Procedures by Modality
☐ Head & neck ☐ Chest ☐ Abdomen ☐ Pelvis ☐	
Thyroid	□ CT (Creatinine level needed within 30 days of
Other:	exam date)
	Specify
	— □ Chest □ Abdomen □ Pelvis
	_   MDI
	☐   □ With Conscious Sedation
	□ With General Anesthesia
	☐ Abdominal (specify)
	_   □ Pelvic
	☐ Thyroid
□ Drainages:	□ Other:
□ Paracentesis □ Thoracentesis	ould.
□ Abcesses: □ Head & neck □ Chest □ Abdomen	
□ Addesses: □ Head & neck □ Chest □ Addomen □ Pelvis	
☐ 1 CIVI2	
□Other:	□ <u>Ultrasound</u>
LOWIN.	☐ Abdominal (specify)
	□ Thyroid
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Physician Signature	(MD, DO, NP, PA) Date:
Scheduled Date: Scheduled time: AM	M / PM Location (Circle): EUH EUHM