

SCHEDULING QUESTIONNAIRE

Appointment Date: _____ Appointment Time: _____

Patient Name: _____ DOB: _____ M F

Phone: _____ Referring Physician: _____

Previous Patient: Yes No Pregnant: Yes No

Insurance: _____ Auth # / Ref #: _____

Scheduled By: _____ Prescription: Will Fax With patient

MRI/MRA: _____

CT/CTA: _____

XR/DEXA: _____

CONTRAST	Y	N	PACEMAKER	Y	N
HIGH B/P	Y	N	ANY IMPLANTED ELECTRONIC DEVICE	Y	N
DIABETIC	Y	N	METAL IN EYES	Y	N
OLDER THAN 60	Y	N	METAL FROM SURGERY OR INJURY	Y	N
KIDNEY DISEASE	Y	N	ANEURYSM CLIPS	Y	N
KIDNEY REMOVED	Y	N	EAR IMPLANT	Y	N
ACTIVE GOUT	Y	N	LUMBAR SPINE SURGERY	Y	N
NEED BLOODWORK	Y	N	PREVIOUS CONTRAST REACTION	Y	N

PREVIOUS RELATIVE STUDIES: Yes No WHERE: _____

ALLERGIES: Yes No ALLERGIC TO: _____

COMMENTS: _____

Special Needs or Assistance (describe): _____

DATE	TIME	RESULT*	COMMENTS	INITIALS

*Left message, scheduled, no answer

Scheduler: _____



OPTIMAL IMAGING
St. Vincent's HealthCare

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CT ■ DEXA ■ MRI ■ Wellness Imaging ■ X-Ray ■ Ultrasound