GARDEN CITY DIAGNOSTICS

Prescription

1808 Palace Drive • Suite # A • Garden City, KS 67846
Phone: 620-275-1864 • Fax: 620-275-1517
Toll Free: 1-866-386-1864

Patient's Name _____ Address _____ Phone: _____

Referred by: _____ Appointment Date: _____ Time: _____

Is the patient pregnant? Yes ☐ No ☐

Recent surgery? Yes ☐ No ☐

Will you need a copy of films? Yes ☐ No ☐

Is this visit due to an injury? Yes ☐ No ☐

If so, please elaborate

Where: _____ When: _____ How: _____

Please check (✔) all that apply:

- ☐ Pacemaker
- ☐ Aneurysm Clips
- ☐ Surgical Clips
- ☐ Tattoos
- ☐ Foreign bodies / Metal in Eyes
- ☐ Prosthetic Device _____
- ☐ Metallic Implants _____
- ☐ Other _____

Diagnosis: _____

Physician's Telephone: _____ Fax: _____ Email: _____

Type of Scan: _____ ☐ Contrast

Body Part to be examined: Please check (✔) specific area(s) of interest

HEAD:

- ☐ Cerebral Hemispheres
- ☐ Brain Stem
- ☐ Temporal Lobes
- ☐ Pituitary (Sella Turcica)
- ☐ Posterior Fossa (C-P Angles)
- ☐ Orbits
- ☐ Other _____

SPINE:

- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbosacral
- ☐ Other _____
- ☐ Other _____

BODY:

- ☐ Chest _____
- ☐ Pelvis _____
- ☐ Abdomen _____
- ☐ Extremity _____
- ☐ Other _____

Prior Radiographic Studies, especially CT scans:

☐ MRI ☐ CT Scan ☐ X-Ray ☐ Other

Dignostic Consideration: _____

Clinical History & Pertinent Information: _____

Referring Physician's Signature

We Will Pre-certify All Insurance Plans With The Following Information:

Insurance _____ Phone: _____

Insured _____ Date of Birth: _____ ID#: _____ Group: _____