Phone: 305-663-8413
Fax: 305-662-8305

❑ New Appointment ❑ Reschedule

MCH Use Only:

Location:____________________

Appointment Date: ____________________

Appointment Time: ____________________

Arrival Time:____________________

Scheduled by:____________________

Special Instructions: ____________________

Confirmation Number:

MRI/CT Appointment Scheduling Form

Procedure:	
Specifications:	Sedation: ❑ Yes ❑ No
	Additional:
Diagnosis:	
Patient:	Name:
	Date of Birth: / Gender: ❑ M ❑ F
Referring Physician:	Name:
	Phone:
	Fax:
Primary Care Physician:	Name:
	Phone:
Patient's Address:	Street:
	City:
	State: / Zip Code:
Phone Numbers:	Primary:
	Secondary:
Mother:	Name:
	Date of Birth:
Father:	Name:
	Date of Birth:
Insurance:	Company:
	Phone Number:
	Policy Number:
	Group Number:
Subscriber:	Name:
	Date of Birth:
Preferred Appointment:	Date:
	Time:
Form Completed by	

Medical History

Does the patient have any metals in the body:
(For example: ear tubes, clips, shunts [programmble or non-programmable], ITB pump, Vagus Nerve Stimulator, braces/dental work)

❑ Yes ❑ No

If any, specify:

Patients over 18, can they physically sign for themselves?

❑ Yes ❑ No ❑ N/A

Mark all of the following that apply:

HISTORY:

❑ Heart Disease

❑ Lung Disease (asthma, pneumonia, bronchitis)

❑ Tuberous Sclerosis

❑ Enlarged tonsils/adenoids/airway issues/snoring

❑ Sleep Apnea

❑ Metabolic Disorder

❑ Congenital Disorder

❑ None

ALLERGIES: ❑ None

❑ Iodine ❑ Gadolinium ❑ Eggs ❑ Mango

❑ Soy ❑ Peanuts ❑ Latex ❑ Seafood

Previous problems with sedation including fiber optic intubations?

❑ Yes ❑ No ❑ N/A

How much does the patient weigh? ________________ lbs

Is the child a ward of the state?

❑ Yes ❑ No

Is the patient less than 52 weeks gestation (applies only for patients age 3 months or preemies less than 6 months)?

❑ Yes ❑ No ❑ N/A

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