Banner Health System

BANNER ALZHEIMER'S INSTITUTE Imaging Referral Form
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Center Use
Pre-Auth
Records
Written Order

Date Order Rec'd.:		**Phys. Office Contact:**	
Ordering Physician:		**Phys. UPIN #:**	
		Phys. NPI #:	
Physician Phone:		**Physician FAX:**	
Patient Name:			
Address:		**DOB / Age:**	
		Weight:	
Home Phone:		**Work / Cell Phone:**	
Check all that apply:	**Pregnant/Nursing?** ☐	**Diabetic?** ☐	**Claustrophobic?** ☐
Medications:		**Previous PET/CT/MRI? Where/when**	
Diagnosis: (Select Scan Below)			
Insurance Company:		**Phone Number**	
Patient SSN / Grp# / Plan# ***(Must have for registration) :***			
Insured Policy Holder ***(if not patient) :***			
Pre-Auth Number:		**Approved by / Contact:**	

PROCEDURE(S) To Be Performed	
☐ **CT Brain w/o Contrast**	☐ **MRI Brain w/o Contrast**
☐ **CT Brain w/Contrast**	☐ **MRI Brain w/Contrast**
☐ **CT Brain w/ & w/o Contrast**	☐ **MRI Brain w/ & w/o Contrast**
☐ **PET/CT FDG Brain**	☐ **MRV**
☐ **PET/CT Amyloid Imaging**	☐ **MRA**
☐ **PET/CT (Other)**	☐ **MRI (Other) (Use Comments below to detail)**
Comments:	

Physician Signature: _____ Date: _____

This section for Imaging Center use only.				
Appointment Date/Time			**Check In Time**	
Confirmed w/Patient?	☐ **Yes** ☐ **No**		**Confirmed w/Physician?**	☐ **Yes** ☐ **No**
Procedure Code:				
Comments/Prep				