NewYork-Presbyterian

Referral Form

Today's Date: _____ Date of Requested Appointment: _____

Patient Name: _____

MRN: _____ Date of Birth: _____ Sex: _____

Patient's Primary Phone #: _____ Patient's Alternate Phone #: _____

Patient's Primary Insurance: _____ Insurance ID #: _____

Insurance Authorization #: _____ Expiration Date: _____

Referring Physician: _____ NPI #: _____

Physician's Phone #: _____ Physician's Fax #: _____

Type of Requested Exam Order: _____

_____

Brief Clinical History: _____

_____

Signs/Symptoms: _____

ICD-10 Code: _____ CPT Code: _____

Any special accommodations i.e. wheelchair, oxygen tank, etc.? _____

Please ask the patient the following questions before scheduling to determine precautions:

- Does the patient have a cardiac pacemaker? ☐ Yes ☐ No
- Does the patient have aneurysm clips? ☐ Yes ☐ No
- Has the patient had any surgery to the ears? ☐ Yes ☐ No
- Is the patient pregnant? ☐ Yes ☐ No
- Is the patient claustrophobic? ☐ Yes ☐ No
- Does the patient weigh over 300lbs? ☐ Yes ☐ No

Please provide patient with the following instructions:

- Arrive 30 minutes prior to appointment time.
  - Please ensure to bring photo ID, insurance card, referral for exam, and any applicable co-pay if any.
- Please be aware of any eating or drinking restrictions provided when appointment was scheduled.

Signature of Requesting Physician: _____

Physician Stamp:

Please submit completed form via Fax or Email:

Fax: 212-305-7944

Email: cumcradiology@nyp.org

NewYork-Presbyterian COLUMBIA