Hartford HealthCare | Midstate RADIOLOGY ASSOCIATES LLC

Scheduling Number: 844-868-1001
Fax: 203-694-7756
www.midstateradiology.com

APPOINTMENT LOCATION:

- ❑ Bristol – Hartford HealthCare HealthCenter – Imaging
- ❑ Cheshire Imaging
- ❑ MidState Medical Center – Radiology
- ❑ MRI of New Britain
- ❑ Mystic Imaging
- ❑ Norwich Imaging
- ❑ Vernon Imaging
- ❑ Wallingford Imaging
- ❑ West Hartford Imaging
- ❑ Whitney Imaging
- ❑ The Hospital of Central Connecticut – Bradley Memorial Campus – Imaging
- ❑ The Hospital of Central Connecticut – New Britain General Campus – Imaging
- ❑ The Hospital of Central Connecticut – Plainville – Imaging
- ❑ Backus Hospital – Imaging
- ❑ Backus Outpatient Care Center
- ❑ Colchester – Hartford HealthCare HealthCenter – Imaging
- ❑ Plainfield Emergency Care Center

PATIENT INFORMATION

Last Name	First Name	Date of Birth	Weight	Height
		/ /		

Address	Home Phone	Other Phone

Primary Insurance (Company)	Policy #	Group #	Authorization #

Secondary Insurance (Company)	Policy #	Group #	Authorization #

MEDICAL HISTORY

Reason for Imaging Services — Symptoms:

❑ STAT

❑ Call ordering provider with results to phone #: _____

❑ Date of Injury: _____

❑ Prior Surgery? When?: _____

Location:
❑ Right ❑ Left ❑ Bilateral
❑ Lower quadrant
❑ Upper quadrant

❑ Call patient to schedule
❑ Patient to take CD

TYPE OF IMAGING REQUESTED

Breast Imaging/Mammography
❑ Comprehensive
Approval to proceed to additional imaging and/or ultrasound to complete Breast Health assessment
❑ Screening
❑ Diagnostic

Date of last Mammogram: _____
Where: _____

Indicate area of interest below:

Right 

Left 

❑ Implants

❑ **CT –** Contrast Per Protocol
❑ With 3D Reconstruction
❑ **DEXA**
❑ **Genetics Consult**
❑ **Interventional Radiology**
❑ **MRI –** Contrast Per Protocol
❑ Arthrogram

❑ **Nuc Med**
❑ **PET**
❑ **Ultrasound**
❑ **X-Ray**

- ❑ Abdomen
- ❑ Abdomen and Pelvis (CT only)
- ❑ Aorta – US only
- ❑ Arterial Doppler– US only
  - ❑ Upper ❑ Lower
- ❑ Arm ❑ Right ❑ Left ❑ Bilateral
- ❑ Ankle ❑ Right ❑ Left ❑ Bilateral
- ❑ Bone Scan (Nuclear Medicine)
  - ❑ Limited area _____
  - ❑ Total Bone
  - ❑ 3 Phase for infection
- ❑ Brain
- ❑ Breast
- ❑ Calcium Scoring (CT only)
- ❑ Carotid Doppler (US only)
- ❑ Cardiac
- ❑ Chest
- ❑ Elbow ❑ Right ❑ Left ❑ Bilateral
- ❑ Extremity – Lower
  - ❑ Right ❑ Left ❑ Bilateral
  - ❑ Bone ❑ Non-Joint ❑ Soft Tissue
- ❑ Extremity – Upper
  - ❑ Right ❑ Left ❑ Bilateral
  - ❑ Bone ❑ Non-Joint ❑ Soft Tissue
- ❑ Facial
- ❑ Femur ❑ Right ❑ Left ❑ Bilateral
- ❑ Finger ____ ❑ Right ❑ Left ❑ Bilateral
- ❑ Foot ❑ Right ❑ Left ❑ Bilateral
- ❑ Forearm ❑ Right ❑ Left ❑ Bilateral
- ❑ Gastric Emptying
- ❑ Hand ❑ Right ❑ Left ❑ Bilateral
- ❑ Head
- ❑ HIDA Scan
- ❑ Hips ❑ Right ❑ Left ❑ Bilateral
- ❑ Humerus
- ❑ IACs – Internal Auditory Canals
- ❑ IVP w/wo & 3D Reconstruction
- ❑ Knee ❑ Right ❑ Left ❑ Bilateral
- ❑ Lung – Low Dose Cancer Screening (CT only)
- ❑ MRCP
- ❑ Neck Soft Tissue
- ❑ OB <14 weeks (US only)
- ❑ OB >14 weeks (US only)
- ❑ Orbits
- ❑ Pelvis ❑ Female ❑ Male
- ❑ Pelvis w/ Transvaginal US if indicated
- ❑ Pituitary
- ❑ Prostate
- ❑ PVR w/ Segmental Pressures
- ❑ Renal ❑ Doppler ❑ Pre/Post Void Bladder
- ❑ Retroperitonal
- ❑ Ribs ❑ Right ❑ Left ❑ Bilateral
- ❑ Sacrum / Coccyx
- ❑ Shoulder ❑ Right ❑ Left ❑ Bilateral
- ❑ Sinus
- ❑ Spine
- ❑ C-Spine – Prior Spine Surgery ❑ Y ❑ N
- ❑ L-Spine – Prior Spine Surgery ❑ Y ❑ N
- ❑ T-Spine – Prior Spine Surgery ❑ Y ❑ N
- ❑ Testicular
- ❑ Thyroid
- ❑ Tibia/Fibula ❑ Right ❑ Left ❑ Bilateral
- ❑ Toe _____ ❑ Right ❑ Left ❑ Bilateral
- ❑ Venous Doppler – DVT
  - ❑ Right ❑ Left ❑ Bilateral
  - ❑ Upper ❑ Lower
- ❑ Whole Body (Gallium Scan)
- ❑ Wrist ❑ Right ❑ Left ❑ Bilateral
- ❑ Other _____

Appointment Day: **Date:** **Time:**

Physician Name: **Phone:**

Physician Signature: **Date:**