



Imaging Authorization Form

Date: _____ Office Contact: _____

Patient Information

Name: _____	DOB: _____
Day phone: _____	Evening phone: _____

Insurance Information

Insurance Carrier: _____	
Insurance Plan: _____	
Policy No (Member ID): _____	Group # _____

Examination Requested

MRI Exam: _____	Contrast <input type="checkbox"/>	Non-contrast <input type="checkbox"/>
CT Exam: _____	Contrast <input type="checkbox"/>	Non-contrast <input type="checkbox"/>
Ordering Physician: _____	C PT: _____	
Diagnosis: _____	IC D9: _____	

Clinical Information

1) Has the patient had any recent imaging done pertinent to their condition? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what? _____
2) Has the patient been prescribed medications? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please list: _____
3) Is the patients' condition due to trauma? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when? _____
4) Conservative therapy or treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, specify: _____
5) Any family history or individual hx of cancer related to the patients condition? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, who and what type? _____

*Please fax this completed form, physicians order, legible copy of insurance card (front and back) and we will facilitate the authorization, pre-certification for the requested imaging service or services.
Orange County Diagnostics would like to thank you for the referral.*