MDi

Authorization# _____ **Effective Date:** _____

Patient Information Name (Last, First MI)	Date of Birth	☐Male ☐Female
Address	Home Telephone	Work Telephone
City State Zip Code	**Date of Exam / Appointment Time:**	

Insurance Information: Plan Type

☐ **HMSA** ☐ **MEDICARE** ☐ **QUEST:** _____ ☐ **MEDICAID** ☐ **HMAA** ☐ **AKAMAI** ☐ **OHANA** ☐ **HMA**

☐ **OTHER**_____ Policy # _____ Group #_____Subscriber_____

☐ **NO FAULT** ☐ **WORKMAN'S COMP**

Company (Responsible Party) _____Claim # _____

Adjuster name /Phone # _____(___)_____-_____ Date of Accident _____

Is Patient Pregnant? ☐ YES ☐NO ***All pregnant patients will be required to sign a consent form.***

Referring Physician	Signature **X**	Date
Additional Report To: (Please Print)	☐ **PER RADIOLOGIST RECOMMENDATION**	
	CHECK ONE BOX: ☐WITH IV contrast ☐WITHOUT IV contrast ☐WITHOUT & WITH IV contrast	
Diagnosis Code: (Please write full description)	**IF APPLICABLE** ☐ w/ Transvag ☐ w/o Transvag	
	EXAM REQUESTED:	
	Preliminary Report Requested ☐ **Yes** ☐ **No** Fax #:	

PLEASE COMPLETE THE BOTTOM PORTION OF THIS FORM; IT WILL GREATLY ASSIST US IN SERVING THE PATIENT.

☐ **BUN** _____ **Creatinine**_____ Date Drawn _____ *Labs only required for patients w/contraindications for MRI/CT with Contrast

☐ **ALLERGIES**_____

☐ **MRI Contraindications (Please check if the patient has any of these)**

- ☐ Pacemaker or implanted pacemaker leads
- ☐ Intravascular coils, stents & filters if recently placed
- ☐ Cardiac implanted defibrillator
- ☐ Intracranial aneurysmal clips
- ☐ Intravascular clamps/clips used for carotid artery surgery
- ☐ Cardiac implants/occluders
- ☐ Intraventricular shunt tube connectors or valves
- ☐ Retinal tack
- ☐ Bullets, shrapnel, metal foreign bodies (near vital organs)
- ☐ Deponit nitroglycerin patch
- ☐ Neurostimulator/Biostimulator
- ☐ Permanent eyeliner or tattoos
- ☐ Middle ear prosthesis
- ☐ Penile implants
- ☐ History of cancer
- ☐ Artificial eye
- ☐ **Metal in eyes: All patients who have had injury to the eyes, involving fragments being lodged in or around the eye must get orbital x-rays to rule out any metallic foreign body. This should be done prior to MRI appointment. Please fax or send the orbit report to our office.**

Is patient claustrophobic? ☐ No ☐ Yes

Previous exams of the area to be imaged? ☐ No ☐ Yes Where? _____When? _____

Previous surgery of the area to be imaged? ☐ No ☐ Yes Where? _____When? _____

Patient Weight _____lbs.

MAUI DIAGNOSTIC IMAGING

SCHEDULING 877-6402

PLEASE FAX REQUISITIONS TO 877-7682 For Triangle Square Exams

OR 874-9224 For Kihei Clinic Exams

☐ **Triangle Square MRI, CT, XRAY, DIGITAL MAMMOGRAPHY, BONE DENSITOMETRY, ULTRASOUND**
425 Koloa Street, Kahului, HI 96732 Phone 877-6402 • Fax 877-7682

☐ **Kihei-Wailea Medical Center XRAY, ULTRASOUND, MAMMOGRAPHY**
Pi`ilani Village Shopping Center, 221 Piikea Avenue, Suite B, Kihei HI 96753 Phone 874-9266 • Fax 874-9224

☐ **Wailuku Clinic XRAY** 99 S. Market Street. Wailuku, HI 96793 Phone 242-5832 • Fax 242-5832

Visit our website at www.MDiMaui.com

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