BOYS TOWN National Research Hospital

CT/MRI UNDER ANESTHESIA SCHEDULING FORM

Referring Provider: _____

Office phone number: _____**Office contact person**:_____**BT Scheduler**:_____

Patient name: _____ **DOB:**_____ ☐ **Male** ☐ **Female**

Address: _____

Parents/Legal guardian: _____ **Relationship to patient:** _____

Phone numbers: Home: _____ **Work:**_____**Cell:**_____

Diagnosis with ICD-10 codes: _____

_____

Procedure:

☐ **CT Scan of**_____**with and / or without contrast under general anesthesia**

☐ **MRI of**_____**with and / or without contrast under general anesthesia**

Admission type: ☐ **Same Day Surgery**

Preferred language for healthcare:_____**Interpreter (including sign) needed:** ☐ **Yes** ☐ **No**

History & Physical to be completed by: ☐ **PCP -- Name:**_____**Phone:**_____

Specific patient, procedure or treatment needs: _____

_____

Insurance Coverage (please fax copy of card): _____

Employer: _____

Subscriber: _____ **Subscriber Date of Birth:** _____

Policy #_____ **Group #**_____

Benefits & Eligibility Phone #_____

Initiate anesthesia protocol (Anesthesiology will obtain informed consent for the anesthesia)

_____ _____ _____

Provider Signature **Date** **Time**

EMAIL COMPLETED SHEET TO surgery.scheduling@boystown.org or FAX: 531-355-0012 QUESTIONS, CALL: 531-355-7799