BOYS TOWN National Research Hospital

CT/MRI 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:

_____

_____

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 WEST

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: _____

Policy Holder: _____Policy # _____Group # _____

Benefits & Eligibility Phone #_____

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

Physician Signature: _____Date: _____Time:_____

EMAIL COMPLETED SHEET TO surgery.scheduling@boystown.org or FAX: 402-758-7778 QUESTIONS, CALL: 402-758-7777