

Patient Information				Insurance Information			
First Name _____		Last Name _____		Insurance _____		Insurance Number _____	
Home Phone _____		Other Phone _____		Secondary Insurance _____		Secondary Insurance Number _____	
Date of Birth _____		Weight _____		Patient to take CD <input type="checkbox"/> Yes / <input type="checkbox"/> No		Authorization # _____	
_____ / _____ / _____						Secondary Authorization # _____	

Specify Criteria & Exam *Check more than one if applicable. Visit jeffersonradiology.com/referring-providers to download our ordering guide.*

<input type="checkbox"/> STAT <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> Abdomen & Pelvis (CT only) <input type="checkbox"/> Abdomen <input type="checkbox"/> Ankle <input type="checkbox"/> Cardiac (CT only) <input type="checkbox"/> Chest <input type="checkbox"/> C-Spine <input type="checkbox"/> Elbow <input type="checkbox"/> Extremity - Lower _____ <input type="checkbox"/> Extremity - Upper _____ <input type="checkbox"/> Facial <input type="checkbox"/> Foot <input type="checkbox"/> Head/Brain <input type="checkbox"/> Hips <input type="checkbox"/> IACs <input type="checkbox"/> Knee <input type="checkbox"/> L-Spine <input type="checkbox"/> Neck Soft Tissue <input type="checkbox"/> Orbits <input type="checkbox"/> Pelvis <input type="checkbox"/> Pituitary <input type="checkbox"/> Ribs <input type="checkbox"/> Shoulder <input type="checkbox"/> SI Joints <input type="checkbox"/> Sinus <input type="checkbox"/> Temporal Bone <input type="checkbox"/> Testicular <input type="checkbox"/> Thyroid <input type="checkbox"/> TMJ <input type="checkbox"/> T-Spine <input type="checkbox"/> Wrist <input type="checkbox"/> Other: _____	<input type="checkbox"/> X-RAY <input type="checkbox"/> Breast Imaging <i>Implants? Y / N</i> Screening <input type="checkbox"/> 3D Screening Mammography <input type="checkbox"/> Proceed to screening breast ultrasound if dense breast <input type="checkbox"/> Proceed to diagnostic mammography and/or diagnostic ultrasound to complete assessment Diagnostic ≥ 30 Years of Age Diagnostic ≤ 30 Years of Age <input type="checkbox"/> Diagnostic mammogram <input type="checkbox"/> Diagnostic ultrasound w/ultrasound if further w/mammogram if clinical assessment further clinical assessment required required <input type="checkbox"/> Axilla <i>(Include bilateral/unilateral mammogram if clinically indicated)</i> Biopsy Advanced Breast Imaging <input type="checkbox"/> Ultrasound Guided <input type="checkbox"/> MR Breast (Bilateral) <input type="checkbox"/> Stereotactic <input type="checkbox"/> Galactogram/Ductogram	<input type="checkbox"/> Bone Densitometry <input type="checkbox"/> screening <input type="checkbox"/> diagnostic <input type="checkbox"/> CT <i>Contrast at discretion of radiologist</i> Creatinine: _____ Date drawn: _____ <i>(Required for CT contrast, within 90 days of appointment for patients over 65 years of age, with kidney disease or diabetes.)</i> <input type="checkbox"/> Calcium Scoring <input type="checkbox"/> Enterography/Small Bowel - <i>Must list secondary diagnosis:</i> _____ <input type="checkbox"/> Sinus w/Surgical Navigation Protocol <i>Specify Protocol:</i> _____ <input type="checkbox"/> Virtual Colonography <input type="checkbox"/> Kidney Stone Study <i>(KUB if stone is present but not seen on scout view)</i> <input type="checkbox"/> CT Urogram <input type="checkbox"/> w/ 3D recon	<input type="checkbox"/> Nuclear Medicine <i>Requires 24 hour cancellation notice</i> <input type="checkbox"/> Bone Scan <input type="checkbox"/> Total Bone <input type="checkbox"/> Limited Area: _____ <input type="checkbox"/> SPECT <input type="checkbox"/> 3Phase for Infection/ Osteomyelitis, Loose Hardware <input type="checkbox"/> Captopril <input type="checkbox"/> DatScan (Parkinson's) <input type="checkbox"/> Gallium Scan <input type="checkbox"/> Whole Body <input type="checkbox"/> Limited Area: _____ <input type="checkbox"/> Gastric Emptying Scan <input type="checkbox"/> HIDA Scan with CCK <input type="checkbox"/> Liver SPECT Scan - for Hemangioma <input type="checkbox"/> Liver Spleen Scan <input type="checkbox"/> MUGA Scan for LVEF (Resting Only) <input type="checkbox"/> Parathyroid Scan <input type="checkbox"/> I-131 Post Treatment Scan: 5-10 Days Post Tx <input type="checkbox"/> Radioiodine Treatment for Hyperthyroidism <input type="checkbox"/> Radioiodine Treatment for Cancer <input type="checkbox"/> w/Thyrogen <input type="checkbox"/> Renal Scan: <input type="checkbox"/> w/Lasix <input type="checkbox"/> Cortical Imaging <input type="checkbox"/> Thyroid Scan <input type="checkbox"/> Uptake <input type="checkbox"/> White Blood Cell Scan (WBC) for Infection <input type="checkbox"/> I-131 Whole Body Scan <input type="checkbox"/> w/Thyrogen
	<input type="checkbox"/> Ultrasound <input type="checkbox"/> Abdomen <input type="checkbox"/> Complete <input type="checkbox"/> Limited <input type="checkbox"/> Abdominal Doppler <i>Specify Organ: _____</i> <input type="checkbox"/> Aorta <input type="checkbox"/> Arterial Doppler Arm w/ WBI <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Arterial Doppler Leg w/ ABI <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Carotid Doppler <input type="checkbox"/> Pelvic <i>(w/transvaginal and spectral Doppler, if clinically indicated)</i> <input type="checkbox"/> Multilevel PVR w/Segmental Pressures <i>(Includes limited duplex)</i> <input type="checkbox"/> OB 1st Trimester <i>(≥ than 11 weeks)</i> <input type="checkbox"/> Renal Only <input type="checkbox"/> Renal/Bladder <input type="checkbox"/> Venous Vein Mapping/Reflux study <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Venous Doppler <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Arm <input type="checkbox"/> Leg <input type="checkbox"/> Other: _____	<input type="checkbox"/> MRI <i>Contrast at discretion of radiologist.</i> <i>Screening orbits performed if clinically indicated.</i> <input type="checkbox"/> MRCP w/Abdomen and 3D - <i>Must List Secondary Diagnosis:</i> _____ <input type="checkbox"/> Enterography/Small Bowel - <i>Must List Secondary Diagnosis:</i> _____ <input type="checkbox"/> MR Arthrogram Joint: _____ <input type="checkbox"/> Brachial Plexus <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> R	
	<input type="checkbox"/> 3D Reconstruction: <input type="checkbox"/> MRA <input type="checkbox"/> CTA	<input type="checkbox"/> Consult <input type="checkbox"/> Uterine Fibroid Treatment <input type="checkbox"/> Varicose Vein Treatment <input type="checkbox"/> Other: _____	

Signs & Symptoms *ICD-10 requires listing of primary and secondary diagnosis (MUST LIST SPECIFICS, "rule out," "history of" or "question of" is not sufficient for insurance)*

Acute Chronic Injury related? Date of Injury: _____ / _____ / _____

When more than one exam is required, specify which body parts apply below.

Referring Provider (print): _____ Signature (required): _____ Date: _____ / _____ / _____

After Hours #: _____ CC Provider Name(s): _____

Scheduling Your Imaging Exam

To best serve you, our team will be in touch to schedule your exam. Please do not hesitate to contact us in the meantime.

Appointment date: _____

Appointment time: _____

Location: _____

Scheduling: 860-289-3375

www.jeffersonradiology.com

OFFICE	DIRECTIONS	Vascular Ultrasound	General Radiology (X-Ray)	3D Tomosynthesis	Bone Densitometry	Iht Mammography	Nuclear Medicine	Ultrasound	CT Scan	Open MRI (High Field)	3T MRI (High Field)	MRI (High Field)
<input type="checkbox"/> 100 Simsbury Road, Suite 101 Avon, CT 06001	From Simsbury, follow Route 10 South to light. Turn L into Avon Wellness Center. From I-84 East or West , take Exit 39. Go straight onto Route 4 W to intersection of Routes 10/202. Turn R on Route 10 N to Route 44. Turn L on Route 44 W. Turn R on Route 10/202 N. Go 1/4 mile and turn R into parking lot at light (Avon Wellness Center).	■	■	■	■	■	■	■	■	■	■	■
<input type="checkbox"/> 6 Northwestern Drive, Suite 102 Bloomfield, CT 06002	From I-91 South , take exit 35B. At the end of the ramp, turn R onto Route 218 and go approximately 4.4 miles. After railroad tracks turn L at light onto Northwestern Drive. From I-91 North , take exit 35B. At the end of the ramp, turn L onto Route 218 and go approximately 4.4 miles. After railroad tracks turn L at light onto Northwestern Drive. From I-291W take Exit 1 for CT-218. Merge onto Putnam Hwy. Turn L onto Route 218 and go approximately 2.6 miles. After railroad tracks turn L at light onto Northwestern Drive.	■	■	■	■	■	■	■	■	■	■	■
<input type="checkbox"/> 100 Hazard Avenue, Suite 100 Enfield, CT 06082	From I-91 North or South , take Exit 47 E, go through 6 traffic lights. The driveway is on the right.	■	■	■	■	■	■	■	■	■	■	■
<input type="checkbox"/> 399 Farmington Avenue, First Floor Farmington, CT 06032	From I-91 North or South , take Exit 32A(84 West). Take 84 W to Exit 39. At end of ramp, take R at 1st light onto Farmington Avenue. Take R at 1st light onto South Road. Take L at 1st light into Farmington Medical Arts Center. From 84 East or West , take Exit 39. At end of ramp, take R at 1st light onto Farmington Avenue. Take R at 1st light onto South Road. Take L at 1st light into Farmington Medical Arts Center.	■	■	■	■	■	■	■	■	■	■	■
<input type="checkbox"/> 704 Hebron Avenue, Suite 100 Glastonbury, CT 06033	From Route 2 West , take Exit 8. Turn R on Oak Street, R on Hebron Avenue, R on Oakwood Drive (entrance on L). From Route 3 E and I-84 E or W to Route 2 East , take Exit 8 off of Route 2. Turn L on Hebron Avenue, then R on Oakwood Drive (entrance on L).	■	■	■	■	■	■	■	■	■	■	■
<input type="checkbox"/> 18 East Granby Road, Suite 202 Granby, CT 06035	From I-91 North or South , take exit 40 (Bradley International Airport). Merge onto Route 20. Take fourth exit for Route 20 East Granby, Granby. Travel approximately 5 miles. Turn R into parking lot (across from Geissler's Supermarket). From CT-219N/Gavitt Rd - Turn R onto CT-20E/ Hartland Road and go approximately 3.6 miles. Turn R onto Salmon Brook Street. Take first L onto East Granby Road. Office will be on left.	■	■	■	■	■	■	■	■	■	■	■
<input type="checkbox"/> 85 Seymour Street, Suite 200 Hartford, CT 06106	From I-91 North or South , take Exit 29A. Go around rotary and take Hudson Street to the end. Turn R on Jefferson Street, then L on Seymour Street. From I-84 West , take Exit 54. Go over Founders Bridge. At light turn L onto Columbus Blvd. Follow blue H (hospital) signs. Turn L onto Seymour Street. From I-84 East , take Exit 48A/48B (Asylum Street/Capitol Avenue). Turn L onto Capitol Avenue. Turn R onto Washington Street. Go through light at intersection of Washington Street and Jefferson Street, at next light L onto Seymour Street.	■	■	■	■	■	■	■	■	■	■	■
<input type="checkbox"/> 941 Farmington Avenue West Hartford, CT 06107	From I-84 East or West , take Exit 43. Turn R on Park Road, then immediate L onto Trout Brook Drive. Turn L on Farmington Avenue (office on L). From Route 44 East , turn R on North Main Street, then L onto Farmington Avenue (office on R).	■	■	■	■	■	■	■	■	■	■	■
<input type="checkbox"/> 1260 Silas Deane Highway, Suites 100 & 104 Wethersfield, CT 06109	From south of Wethersfield take I-91 North and take Exit 24. Turn R on Silas Deane Highway (office on R). From north of Wethersfield take I-91 South and take Exit 24. Turn L onto Silas Deane Highway (office on R). From Route 3 West , turn L on Silas Deane Highway (Route 99). Office is about 1 mile on L. From Route 175 E (Cedar Street in Wethersfield), turn R on Silas Deane Highway (office about 3 1/2 miles on L).	■	■	■	■	■	■	■	■	■	■	■

PATIENT INSTRUCTIONS — If prior images are not at Jefferson Radiology, please bring films or images on a CD at time of appointment. For breast imaging patients, please bring your last five (5) years of imaging history. If you have an appointment for any of the examinations listed below, please follow the instructions for preparation unless they are modified by your own doctor or by us.

ALL PATIENTS MAY BE REQUIRED TO CHANGE.

PATIENT INSTRUCTIONS FOR GENERAL X-RAY

- MAMMOGRAPHY:** Do not use any deodorant, cream or powder in the underarm or breast area prior to the examination.
- BONE DENSITOMETRY:** This examination should not be done within 2 weeks of a nuclear medicine procedure, within 1 week of any contrast study or 48 hours post barium study. Do not take calcium supplements for 24 hours prior to examination.

PATIENT INSTRUCTIONS FOR ULTRASOUND EXAMINATIONS

- PREGNANCY OR PELVIC ULTRASOUND:** Drink 32 oz. of water and FINISH drinking 60 minutes before scheduled exam. Do not urinate until the exam is complete. Males: no prep required.
- ENDOGENOUS ULTRASOUND:** No prep.
- ABDOMINAL ULTRASOUND (Gallbladder, Aorta, Liver):** Nothing to eat or drink (including water) 6 hours prior to your exam.
- RENAL ULTRASOUND:** Drink 24 oz. of water and FINISH drinking 60 minutes before scheduled exam. Do not urinate until the exam is complete.

PATIENT INSTRUCTIONS FOR MRI / MRA OF THE ABDOMEN AND THE PELVIS

- Nothing to eat or drink (including water) 4 hours prior to your exam.

PATIENT INSTRUCTIONS FOR CT SCAN

- GENERAL INSTRUCTIONS FOR CT SCAN:** Nothing to eat or drink (including water) during the two hour period before your appointment. Medications may be taken normally and a list should be brought to your appointment.
- CT SCAN OF HEAD, NECK, CHEST:** Follow general instructions above.
- CT SCAN OF ABDOMEN/PELVIS:** Patients will need to drink a Readi-Cat solution 1-1/2 hour prior to their exam. Patients can either pick up the solution prior to their appointment or arrive 1-1/2 hour before their exam and drink it on site. Readi-Cat can be picked up at any of our Jefferson Radiology locations. Patients should not eat 2 hours prior to exam if they are having IV contrast.

PATIENT INSTRUCTIONS FOR NUCLEAR MEDICINE

- BONE SCAN:** No restrictions. Allow 15 minutes for injection. You will return 2-1/2 to 3-1/2 hours later for imaging. Allow 1 hour for the examination. Wear comfortable clothing.
- BILIARY SCAN:** Nothing to eat or drink for 4 hours before the scan. No pain medication 4 hours prior to the exam. Allow 2 hours for the examination.
- GASTRIC EMPTYING SCAN:** Nothing to eat or drink for 4 hours before the scan. Allow 2-4 hours for the examination.
- CAPTOPRIL RENAL SCAN (2-day Exam):** Certain blood pressure medications may need to be stopped for this procedure. This should be discussed with your doctor.
- THYROID UPTAKE AND SCAN (2-day Exam) / PARATHYROID SCAN (1-day Exam) / THYROID SCAN (1-day Exam):** Certain medications need to be stopped before this procedure. This can be discussed with your doctor.