Connecticut Children's MEDICAL CENTER

REFERRAL/ORDER FORM
RADIOLOGY

Radiology Modalities:
Fluoroscopy / X-Ray / CT / Ultrasound / MRI
For Scheduling: 860.837.7600

Connecticut Children's Patient Label
for internal use only

Patient Name: (Last) _____ (First) _____

Street Address: _____

City/State/Zip: _____ **Date of Birth:** _____

Preferred Phone: (Home) _____ (Work) _____ (Cell) _____

Parent/Guardian/DCF: _____ **Preferred Language:** _____

If DCF: (Social Worker name) _____ (Phone) _____

This visit is: ☐ Routine ☐ Semi-urgent (within 2 weeks) **Urgent: Please call Department for urgent appointments.**

Insurance: _____ **ID#** _____

Expected Date of Examination: _____

Examination Requested: _____

_____

_____

Reason for exam/relevant clinical history: _____

_____

_____

_____

ICD-10 Code(s) (Required): _____

Is Sedation Consult Required? ☐ Yes **(Short H & P form required to schedule appointment. Please attach H&P)**
☐ No For: ☐ Pain ☐ Anxiety ☐ Decrease Movement

Interpreter needed? ☐ Yes ☐ No *What language?* _____

Special Precautions/Allergies _____

_____

Fax copy to Connecticut Children's at 860.837.5649, give original to patient.

REFERRING PROVIDER INFORMATION

Referring Provider: _____

Referring Provider: (Phone) _____ (Fax) _____

Patient's Primary Care Physician (if different from referring)**:** _____

Is the family aware of the reason for referral? ☐ Yes ☐ No

_____ Date _____ Time _____

Signature/Credentials of ordering Practitioner (APRN, PA, Non-resident MD or DO)