

**Imaging Center of Columbus**  
**Referral Sheet**

Date: \_\_\_\_\_ Test: \_\_\_\_\_ Code: \_\_\_\_\_

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**Patient Information**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Weight: \_\_\_\_\_

Patient SS#: \_\_\_\_\_ Home #: (\_\_\_\_) \_\_\_\_\_ Wk #: (\_\_\_\_) \_\_\_\_\_

Patient Address: \_\_\_\_\_  
(Number) (City) (State) (Zip)

Please circle:      Male or Female

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**MRI Information**

Ref MD: \_\_\_\_\_ Name of Scheduling Nurse: \_\_\_\_\_

Dr. Office Phone #: \_\_\_\_\_ Dr. Fax # \_\_\_\_\_

Previous Surgeries: Yes/ No (Explain) \_\_\_\_\_

Prior Studies: Yes/No (Where?) \_\_\_\_\_ Next Dr. Office Visit: \_\_\_\_\_

Does the patient have a pacemaker: Yes/No

Is the patient a metal worker: Yes/No

Diagnosis: \_\_\_\_\_

Study(s) Ordered: \_\_\_\_\_

Appointment Date: \_\_\_\_\_ Appointment Time: \_\_\_\_\_

Scheduled By: \_\_\_\_\_ Dr. Request: \_\_\_\_\_

**Insurance Information**

Type of CLAIM: \_\_\_\_\_ Medical Ins. \_\_\_\_\_ Attorney \_\_\_\_\_ Liability \_\_\_\_\_ Work Comp

Primary Insurance Co: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_

Group #: \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_ ext. \_\_\_\_\_

Name of Adjustor: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Address to mail claim: \_\_\_\_\_

\_\_\_\_\_

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**Benefits**

(Spoke To): \_\_\_\_\_ Date: \_\_\_\_\_

Pre-cert necessary \_\_\_\_\_ no \_\_\_\_\_ yes \_\_\_\_\_ In-Network \_\_\_\_\_ Out of Network

Deductible \*\*\*\*\*

Coverage\*\*\*\*\*

Out-of-pocket\*\*\*\*\*

YTD Deductible Met\*\*\*\*\*

Life-Time Max\*\*\*\*\*

Effective Date: \_\_\_\_\_

Insurance Notes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_