

**CORAL DESERT
IMAGING CENTER**

1490 E. Foremaster Dr. Bldg C
St. George, Utah
Phone 435/986-2238 Fax 435/986-2237

Referring Physician: _____ Phone: _____ Fax: _____

Date/Time of Exam _____

Patient Name (Last, First, M.I.) : _____		DOB: _____
Address: _____	City/State _____	Zip _____
Phone #'s Home: _____	Mobile: _____	
Male <input type="checkbox"/>	Female <input type="checkbox"/>	If minor, Guardian's name: _____
Insurance Information:		
Primary Insurance: _____	Secondary Insurance: _____	
Primary Insurance ID#: _____	Secondary Insurance ID #: _____	
*If workers comp, DOI: _____		Employer: _____

***PLEASE REMEMBER TO SEND PATIENT WITH THEIR REFFERAL*
OR FAX TO OUR OFFICE PRIOR TO EXAM**

CT Scan _____ **MRI Scan** _____

_____ w/o contrast _____ w/ contrast _____ w/ contrast as needed

Does Patient have the following?		Creatinine/Date _____			
Pacemaker	Yes No	Renal Disease	Yes No	Prior Surgery	Yes No
Brain Aneurysm Clip	Yes No	Iodine Allergy	Yes No	Type _____	
Implanted Electrical Devices	Yes No	Diabetic	Yes No	Prior Relevant Imaging	Yes No
Metal Foreign Body in Eye	Yes No	Dialysis	Yes No	Date _____	Where _____

Procedure / Referral Information:

Type of Scan: _____

Reason for Scan / Diagnosis/ICD9: _____

Special Instructions: _____

Physician Signature: _____

***PLEASE NOTE: WE CANNOT PERFORM CT/MRI WITHOUT
PHYSICIAN SIGNATURE.***