

**Patient Information:**

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: \_\_\_\_\_

**Parent/Guardian Information:** Last: \_\_\_\_\_ First: \_\_\_\_\_

Email: \_\_\_\_\_ Preferred Phone: \_\_\_\_\_ Alt Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_ Preferred Language (if not English): \_\_\_\_\_

**Diagnostic Testing**☐ -Ray(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_☐\_\_\_\_\_  
\_\_\_\_\_☐ roscopy: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_☐ exa Scan \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_**\*Requires Prior Authorization prior to referral**Prior Authorization #: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_**Reason for Referral:** \_\_\_\_\_**Preferred Location (if available):****Missouri:** ☐ Independence ☐ Kansas City ☐ Northland (KC)**Kansas:** ☐ Overland Park**Referring Provider Name:** \_\_\_\_\_ NPI (if new referring provider): \_\_\_\_\_**Practice Name:** \_\_\_\_\_ Call with acute findings only ☐ Yes ☐ No**Office Phone:** \_\_\_\_\_ **Office Fax:** \_\_\_\_\_Primary Care Provider: ☐ Same as above Name: \_\_\_\_\_**Signature:** \_\_\_\_\_**Date:** \_\_\_\_\_☐ CT\*: \_\_\_\_\_☐ w/ contrast ☐ w/out contrast  
\_\_\_\_\_  
\_\_\_\_\_☐ w/ contrast ☐ w/out contrast☐ MRI\*: \_\_\_\_\_☐ ☐ w/out contrast ☐ w/ & w/out  
contrast  
\_\_\_\_\_  
\_\_\_\_\_☐ ☐ w/out contrast ☐ w/ & w/ out  
contrast  
\_\_\_\_\_  
\_\_\_\_\_*For MRI only: Is there metal in the patient's body or an  
implanted device?*☐ No ☐ Yes: \_\_\_\_\_☐ ar Medicine\* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_**Diagnostic Testing Urgency:**☐ ☐ Routine