

APPOINTMENT REQUEST

RADIOLOGISTS: CHRISTOPHER MALCOM DO, MICHEAL JOHNSON DO, JOHN GAMBINO MD PHD, ROBERT YEAGER MD

PATIENT INFORMATION

Ordering Physicians Name: _____ Contact Person: _____

Office Phone #: _____ Please Fax Results to: _____

Patient Name: First: _____ Middle: _____ Last: _____

D.O.B.: _____ Contact Phone#: _____ Spanish Speaking Only: ___ Yes ___ No

Insurance: _____




Imaging Center OF IDAHO
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Phone: 208-454-0742
www.ImagingCenterofIdaho.com

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Vein Center OF IDAHO

<p>Meridian 3581 E. Overland Rd. Phone: 208-402-4467</p>	<p>Caldwell 4519 Enterprise Way Phone: 208-454-4976</p>
<p>www.veincenterofidaho.com</p>	
Fax: 321-8626	Fax: 454-4997

SPECIFICATIONS
<p>AUTHORIZATION # _____</p> <p><input type="checkbox"/> MRI (Specify Body Part): _____</p> <p>ARTHROGRAM: ___ Yes ___ No</p> <p>STEROID INJECTION: ___ Yes ___ No</p> <p><input type="checkbox"/> X-RAY (Specify Body Part): _____</p> <p><input type="checkbox"/> CT (Specify Body Part): _____</p> <p><input type="checkbox"/> Bone Density <input type="checkbox"/> BMI</p> <p><input type="checkbox"/> Fluoro: ___ UGI ___ Esophogram</p> <p>___ Barium Enema Other: _____</p> <p><input type="checkbox"/> Ultrasound (Specify Body Part): _____</p> <p><input type="checkbox"/> Mamography</p> <p> Screening _____ Diag _____</p> <p><input type="checkbox"/> Interventional</p>

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SPECIFICATIONS
<p><input type="checkbox"/> Initial Consultation: _____</p> <p><input type="checkbox"/> Varicose Veins: _____</p> <p><input type="checkbox"/> Spider Veins: _____</p> <p><input type="checkbox"/> Leg Pain: _____</p> <p><input type="checkbox"/> Leg Swelling: _____</p> <p><input type="checkbox"/> Ultrasound _____</p> <p><input type="radio"/> Venous Duplex: ___ Unilateral (R/L) ___ Bilateral</p> <p><input type="radio"/> Post OP Duplex: ___ Unilateral (R/L)</p> <p><input type="radio"/> Compression Stockings</p> <p>_____</p> <p>_____</p>

Diagnosis/Symptoms: _____

WE APPRECIATE THE OPPORTUNITY TO SERVE YOU

Provider Signature: _____ **Date:** _____

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ADVANCED OPEN IMAGING

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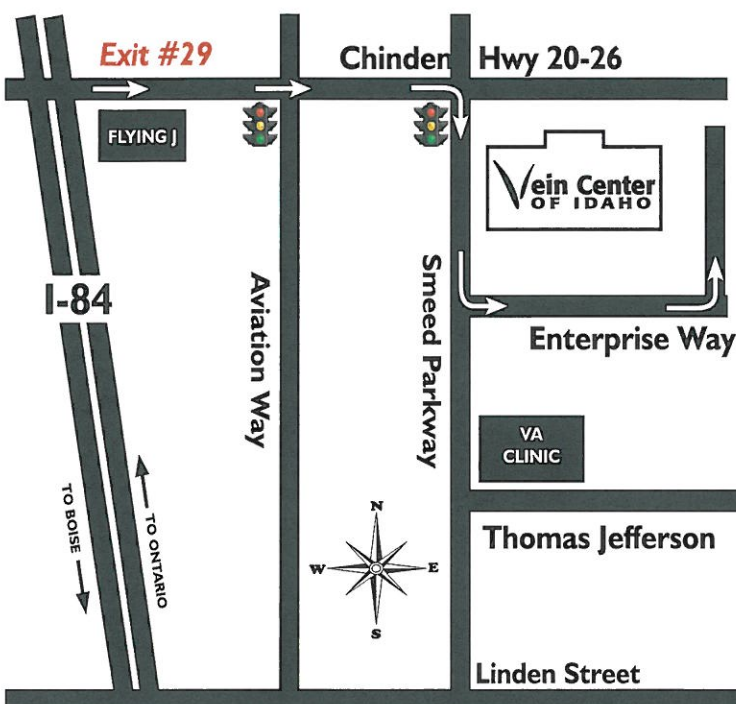
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