NORTHLAND IMAGING

☐ *5500 N. OAK TRAFFICWAY, SUITE 101*
KANSAS CITY, MO 64118

☐ *9151 N.E. 81st TERRACE, SUITE 250*
KANSAS CITY, MO 64158

PHONE 816-452-4674 • FAX 816-452-4679

SCHEDULING FORM

Appointment Date:___________ Time:_________

Permission for Northland Imaging to contact patient to schedule appointment. YES NO

Patient Name:_______________________________ DOB:_______________

Phone (Home):_______________________ (Work):_______________________

Insurance Company:_______________________ PRECERT #:_______________

Member ID#:_______________ Insurance Company Benefit Phone#:_______________

REFERRING PHYSICIAN:_______________________ Phone:_______________

Ordering Nurse:_______________________ Fax:_______________

CT & MRI EXAMS WILL BE PERFORMED WITH AND WITHOUT CONTRAST AT THE DISCRETION OF THE RADIOLOGISTS: UNLESS OTHERWISE SPECIFIED BY ORDERING PHYSICIANS.

All CT/MRI patients 60 and older must have a recent Creatinine for all exams requiring Contrast

MRI		CT	ULTRASOUND	GENERAL X-RAY	
☐ Head		☐ Head	☐ Abdomen Complete	*Available Liberty Office Only*	
☐ IAC'S		☐ Facial Bones	☐ Abdomen/Gallbladder	☐ Chest	
☐ Pituitary		☐ Soft Tissue Neck	☐ Aorta Only	☐ Sinuses	
☐ Orbits		☐ Temporal Bones	☐ Pelvic Non OB	☐ Lateral Neck	
☐ Soft Tissue Neck		☐ Sinuses	☐ Pelvic OB	☐ Abdomen/KUB	
☐ Cervical Spine		☐ Limited Sinuses (Coronal Only)	☐ Biophysical Profile	☐ Ribs	
☐ Thoracic Spine		☐ High Res Chest	☐ Renal	☐ C-Spine	
☐ Lumbar Spine		☐ Chest	☐ Renal Doppler	☐ T-Spine	
☐ Sacrum		☐ PE Chest	☐ Thyroid	☐ L-Spine	
☐ Pelvis		☐ Abdomen	☐ Scrotal	☐ Orbit X-Ray	
☐ MRCP		☐ Renal Stone Study	☐ Carotid Doppler	☐ Pelvis	
☐ Abdomen		☐ Pelvis	☐ Venous Doppler	☐ Hips	RT/LT
☐ Hip	RT/LT	☐ C-Spine	☐ Arterial Doppler	☐ Extremity	RT/LT
☐ Knee	RT/LT	☐ T-Spine	☐ Extremity	☐ Other	
☐ Ankle	RT/LT	☐ L-Spine	☐ Other		
☐ Shoulder	RT/LT	☐ Extremity		**BONE DENSITY (DEXA)**	
☐ Elbow	RT/LT	☐ Other		☐	
☐ Wrist	RT/LT				
☐ Other		**CT ANGIOGRAPHY**			
		☐ CTA Head			
MRA ANGIOGRAPHY		☐ CTA Neck			
☐ MRA Head		☐ CTA Aorta			
☐ MRA Neck		☐ CTA Pulmonary			

DIAGNOSIS/SYMPTOMS _______________________________________

PHYSICIAN'S SIGNATURE _______________________________________

Revised 2/08

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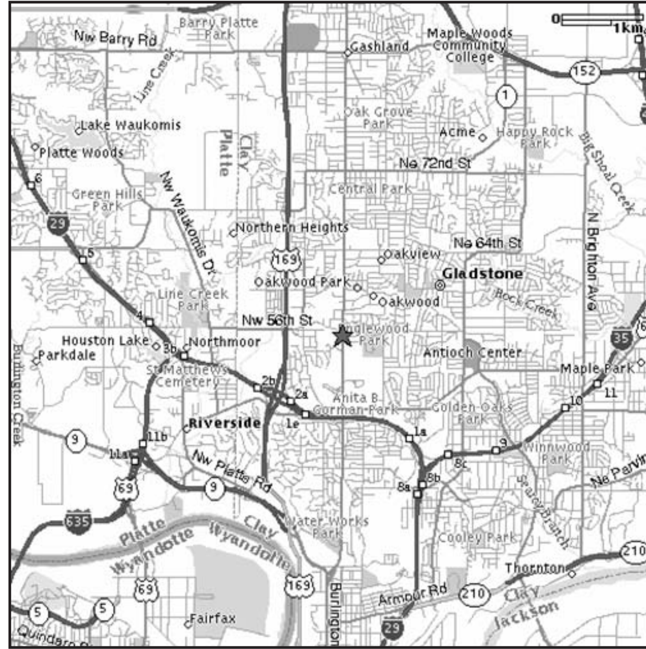

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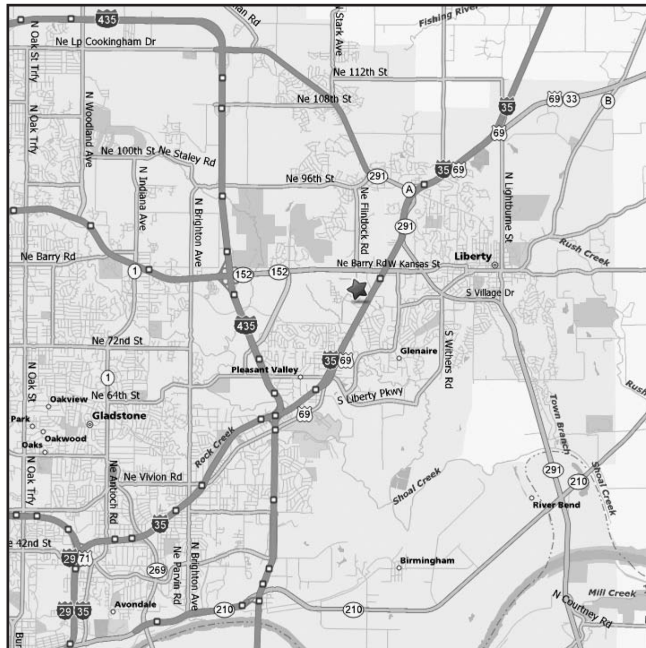

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www.northlandimaging.com