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Referral Form

Examination Appointment

Appointment Date: ___/___/___ Exam Time: _____ HCMC/HFA Medical Record No.: _____
(if applicable) _____

Patient Name: _____

(Last) (First) (MI)

Date of Birth: ___/___/___ Male Female

Please indicate the best daytime number at which to contact the patient:

Home Phone _____
 Work Phone _____
 Cell Phone _____

Referring Physician _____ Clinic Phone _____ Pager _____ Other Phone (Assistant, Cell) _____
Person Making Appointment _____ Clinic Phone _____ Clinic Fax _____

Requested Examination(s):

Clinical Diagnosis/Symptoms:

Referring Physician Signature _____ Date ___/___/___

Previous Studies: HCMC Other (List): _____

Location: _____

Patient will bring Office will mail
 Office will send by courier Films at facility where done/please obtain

Study Results

Call results Phone #: _____ Fax results Fax #: _____
 Send images on CD-ROM to physician w/ report Send images to HCMC PACS
 Send duplicate films to physician w/ report Send duplicate films with patient

Patient Arrival Time

Please arrive 15 minutes prior to your scheduled exam
 30 minutes prior to your scheduled exam
 2 hours prior to your scheduled exam

Patient Exam Preparation

Continue to take prescription medication with small sips of water unless otherwise instructed.

No preparation needed Creatinine blood test in past 30 days?
 Nothing to eat or drink 4 hours before exam If yes, indicate results: _____
 Arrive 2 hours prior to exam for oral contrast No tobacco or caffeine for 2 hours prior
 Follow full bowel preparation instructions to testing