Boys Town National Research Hospital
CT/MRI Scheduling Form

Referring Physician: _____

Office Phone Number: _____ Office Contact Person: _____ BT Scheduler: _____

Patient Information

Patient Name: _____ Date of Birth: _____ ❒ Male ❒ Female

Address: _____ City: _____ State: _____ Zip: _____

Parent(s)/Legal Guardian(s): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

PROCEDURE INFORMATION

Procedure:

❒ CT Scan of _____ with and/or without contrast under general anesthesia.

❒ MRI of _____ with and/or without contrast under general anesthesia.

Diagnosis: _____

Admission type: ❒ Same Day Surgery

Preferred language for healthcare: _____ Interpreter (including sign) needed: ❒ Yes ❒ No

History and physical to be completed by: ❒ PCP – Name: _____ Phone: _____

Specific patient, procedure or treatment needs: _____

_____

Insurance coverage (please fax copy of card): _____

Employer: _____

Policy holder: _____ Policy #: _____ Group #: _____

Benefits and eligibility phone #: _____

Initiate anesthesia protocol (Anesthesiology will obtain informed consent for the anesthesia)

_____ _____ _____

Physician Signature Date Time

FAX COMPLETED SHEET TO: 402-758-7778 • QUESTIONS PLEASE CALL 402-758-7777

BOYS TOWN National Research Hospital®

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