DIAGNOSTIC REFERRAL REQUEST

Please fax this form to (614) 383-6489, call (614) 383-6116, or
use the **Secure Form Submission Tool** on our website.
Copies of this form may be downloaded from our website: www.zangcenter.com

Patient Name: ______________________ Date: ______________________

Patient Address: ____
Street Address City State Zip

Home Phone: ( ) ______________________ Other: ( ) ______________________

DOB: ______________________ SS #: ______________________

Diagnosis/Reason for Consultation: ______________________________

Referring Physician: ______________________ Staff Contact: ______________________

Phone: ______________________ Fax: ______________________

Primary Insurance: ______________________ Secondary: ______________________

Authorization #: ______________________

X-RAY

_____ Chest PA/LAT
_____ Abdomen
_____ Spine *specify*: Cervical Thoracic Lumbar
_____ Shoulder *specify:* L R
_____ Hip *specify:* L R
_____ Ankle *specify:* L R
_____ Foot *specify:* L R
_____ Metastatic Survey
_____ DEXA (Bone Density - includes hip & lumbar)
_____ Other *specify:* ______________________
____

NUCLEAR MEDICINE

_____ Bone Scan
_____ Octreoscan
_____ Liver Scan
_____ MUGA (Multi-Gated Acquisition - Cardiac EF)

CT

____ with contrast ____ without contrast

_____ Chest Angiogram
_____ Chest
_____ Abdomen
_____ Pelvis
_____ Head/Brain
_____ Sinus
_____ Orbits
_____ Neck - soft tissue
_____ Thoracic
_____ Lumbar
_____ Upper Extremity *specify:* ______________
_____ Lower Extremity *specify:* ______________
_____ Other specify: ______________

PET CT

_____ Oncology
_____ Brain (Dementia vs. Alzheimer's)

Physician Signature: ______________________________ Date: ______________