PATIENT INFORMATION
Patient Name: ___________________________ 
Date of Birth: ( / / ) 
Cell Phone: ___________________________ 
Patient E-mail: _________________________ 
ICD-10 Code: ___________________________ 
Reason for Exam: _________________________ 

Please call Patient: yes ☐ no ☐ 
Patient will call to schedule: yes ☐ no ☐ 
Authorization #: _________________________ 
Referral #: ____________________________ 
AUC #: ________________________________ 
Insurance: _____________________________ 
Policy ID #: ___________________________ Group #: __________________________ 
Other Procedures: _________________________ 

REQUESTING PHYSICIAN INFORMATION
Results (Check all that apply) ___________________________ 
E-mail notification: (E-mail) ___________________________ 
Fax report: (Fax #) ___________________________ 
Phone Report: (Phone #) ___________________________ 
Referring Physician Phone: _________________________ 
CD with Images ☐ STAT ☐ Special Request: ___________________________ 

Please print: ____________________________ 

Referring Physician: _________________________ 
Referring Physician Signature: _________________________ 

Referring Physician authorizes Houston Medical Imaging (i) to contact patient's managed care plan or other insurer on behalf of 
Referring Physician to pre-certify the patient for the procedure being requested and (ii) to provide scheduling services for the patient being referred.
PATIENT INFORMATION

Patient Name: ____________________________
Date of Birth: ( __/__/__ )
Cell Phone: _______________________________
Patient E-mail: __________________________
ICD-10 Code: _____________________________
Reason for Exam: __________________________

Please call Patient yes ☐ no ☐
Patient will call to schedule yes ☐ no ☐
Authorization #: __________________________
Referral #: _______________________________
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Other Procedures: _________________________

REQUESTING PHYSICIAN INFORMATION

Results (Check all that apply)

E-mail notification: (E-mail) ________________
Fax report: (Fax #) _______________________
Phone Report: (Phone #) ___________________
Referring Physician Phone: __________________
CD with images ☐ STAT ☐
Special Request: __________________________

Referring Physician: _______________________
(Please print)
Referring Physician Signature: _______________