Children's MINNESOTA

Phone: 612-874-5399
Please fax form to: 612-813-7669

Medical Imaging Request Form

FILL OUT FORM COMPLETELY PRIOR TO SUBMITTING

*****Please be advised we do not currently make outbound calls – allow 2 hours of processing prior to family request to schedule.**

Children's MRN:			
Patient Legal Name	Last:	Full Middle:	First:
Preferred Name: Pronouns:		Patient DOB:	Legal Sex: ☐ Male ☐ Female Birth Sex: ☐ Male ☐ Female
Patient Address:		Primary Cell Phone # : Other Phone #: Preferred method to contact: ☐ Call ☐ Email ☐ Text ☐ Permission to Text Preferred Family Email:	
Preferred Language: Interpreter Needed: ☐ No ☐ Yes			
Imaging Order:		Contrast: ☐ W ☐ W/O ☐ W & W/O	
Diagnosis:		ICD-10 Code:	
Ordering Physician:		Physician's Signature:	
Sedation: ☐ Yes ☐ No		Comments:	
Demographic Information ☐ There are guardian issues/concerns (Please attach any legal custody documents)		☐ Patient only has one legal guardian	
Legal Guardian 1 Name:		Legal Guardian 2 Name:	
Legal Guardian 1 Phone #:		Legal Guardian 2 Phone #:	
Legal Guardian 1 DOB:		Legal Guardian 2 DOB:	
Relationship to Patient: Parent/Guardian Address (if different than patient or enter N/A):		Relationship to Patient: Parent/Guardian Address (if different than patient or enter N/A):	
Is this person able to sign consent: ☐ Yes ☐ No		Is this person able to sign consent: ☐ Yes ☐ No	
Insurance Type: Group #: Member ID #: Policy Holder Name: DOB: Relationship to patient: Prior Auth #: ***** Insurance must be current active coverage & include a copy of the card**		Insurance Type: Group #: Member ID #: Policy Holder Name: DOB: Relationship to patient: Prior Auth #: ***** Insurance must be current active coverage & include a copy of the card**	
Ordering Clinic: Phone #: Email: Return Fax Number:			