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MICHAEL A. BARON, M.D., LTD.
BOARD CERTIFIED IN
DIAGNOSTIC RADIOLOGY AND
NUCLEAR MEDICINE

Today's Date ______________ Appointment: Date ______________ Time ______________

Patient's Name ______________________________ D.O.B. ______________

Address ______________ City ______________ State ________ Zip ________

Phone: Day ______________ Evening ______________ ❑ **Motor Vehicle Accident/Injury/Work Related**

CLINICAL INFORMATION *(reason for exam)*: ______________________________

ALLERGIES ______________ CPT Code(s): ______________ ICD-9 Codes(s): ______________

Insurance/Policy Number ______________________ Auth/Claim No. ______________

Other Information ______________________________

MRI Scans: **IV Contrast: ❑ Yes/if indicated** MRI: ❑ Spine(C,T,L) ______________ ; ❑ Brain; ❑ IAC's; ❑ Abd; ❑ Pel;
❑ Chest; ❑ Breast; ❑ Shoulder; ❑ Knee; ❑ Wrist; ❑ Hand; ❑ Hips; ❑ Ankle; ❑ Foot; ❑ Right; ❑ Left; ❑ Bilat;
❑ Other (area) ______________________ ❑ **MRA** (area) ______________

CT Scans: **IV Contrast: ❑ if indicated** ❑ ABD/PEL; ❑ PEL; ❑ Chest; ❑ Head (Brain); ❑ Sinuses;
❑ IAC's; ❑ Neck; ❑ Kidney Stone Protocol; ❑ 3D Reconstruction; ❑ Cardiac Scoring;
❑ Other ______________________ ❑ **CTA** (area) ______________________

Ultrasound: ❑ Pelvic and/or T-Vag; ❑ OB (1st, 2nd/3rd Tri) ❑ Abdomen; ❑ Thyroid; ❑ Right Upper Quadrant; ❑ Renal;
Extremity: ❑ Upper ❑ Lower ❑ Right ❑ Left ❑ Bi ❑ Venous ❑ Arterial ______________________;
❑ Scrotum With Doppler; ❑ Breast ❑ Right ❑ Left ❑ Bi ❑ Other US ______________________

❑ **X-Ray** ______________________________

❑ **Dexa (Bone Density)** ❑ **Fluoroscopy** ______________________

❑ **Nuclear Medicine** ______________________________

❑ **Mammography:** ❑ Annual Screening ❑ Diagnostic (with Breast US, if indicated) Symptoms ______________
❑ Implants

❑ **PLEASE CALL PATIENT TO SCHEDULE APPOINTMENT**

Additional Comments or Instructions: ______________________________

PLEASE SEND **ALL** PREVIOUS: MRI, C.T., X-Ray, Nuc. Med., Ultrasound, Mammo, etc. examinations WITH PATIENT FOR A **COMPLETE** EVALUATION!!!

❑ Send films with patient ❑ Fax Report to ______________________
Fax Number

❑ Routine Report (Report only) ❑ Prefer CD to films

❑ Send films and report to office

❑ I would like a call concerning the results of the examination(s) performed.

❑ **STAT** – Call Results to: ______________________ and ❑ Hold Patient or ❑ Release Patient
Phone Number

❑ Would you like internet access to: ❑ Report(s) and/or ❑ Diagnostic Examination(s) of your patient?

______________________ ______________________
REFERRING PHYSICIAN PHONE

Patient or Physician should call to schedule examination(s) at (702) 433-6100