FAX SCHEDULING FORM

CENTRAL PENINSULA HOSPITAL DIAGNOSTIC IMAGING DEPARTMENT
250 Hospital Place, Soldotna, Alaska 99669
Telephone: 907-714-4420 / 907-714-4542
Fax: 907-714-4957

Patient Name: ______________________________ DOB: ____________ Sex: M F
(Last) (First)

Referring Physician: ______________________________ Today's Date: ________________

Physician Fax Number: __________________ Physician Phone Number: ___________________

Exam Requested **(Please Print)**: ____

Diagnosis **(Please Print)**: ____

Specific Focus of Clinical Concern (Please Print): ______________________________________

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Allergies: ____

Is the patient Pregnant? Y N

Is the patient a Diabetic? Y N * If Yes
* Is the patient taking Metformin/Glucophage? Y N

Telephone number where patient can be reached: _________________________

Best time to call: ____________ am ____________ pm

________________________________ ________________________
Physician Signature **Date / Time**

PLEASE COPY BOTH SIDES OF THE PATIENT'S INSURANCE CARD AND ANY AUTHORIZATIONS AND FAX TO US IMMEDIATELY

(FOR CPGH USE ONLY)

ORDER CONFIRMATION:

Your patient has been scheduled for the examination requested above on:

Date: ____________________ Time: ______________

Scheduler Signature: ______________________________

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