(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

UAMS RADIOLOGY PATIENT SCHEDULING INFORMATION FORM

4301 West Markham Little Rock, Arkansas 72205
501-526-6527

DATE: ________________________

PLEASE RETURN THIS FORM WITH ORDERED EXAM TYPE AND CLINICAL INFORMATION REQUEST, PRESCRIPTION, REFERRAL, OR ORDERING SERVICE LETTERHEAD WITH *DOCTOR'S SIGNATURE*

FAX TO: 501-686-8452

PATIENT NAME ____
D.O.B. ____
WEIGHT __________________ **HEIGHT** __________________
ADDRESS ____
PHONE NUMBER ____

INSURANCE COMPANY ____
PHONE NUMBER ____
PRECERT # REQUIRED? ☐ **YES** ☐ **NO (PLEASE CALL INSURANCE COMPANY TO VERIFY)**
PRECERT # __________________

TYPE OF RADIOLOGY EXAM ____
DIAGNOSIS ____

DOCTOR'S NAME ____
ADDRESS/PHONE NUMBER ____
____
DOCTOR'S SIGNATURE ______________________________ **DATE/TIME** __________________

PRIMARY CARE PHYSICIAN ____
ADDRESS/PHONE NUMBER ____
____
UPN # __________________ **MEDICARE #** __________________

CLINIC CONTACT NAME AND PHONE NUMBER FOR RETURN CALL WITH THE TIME/DATE

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*****SPECIAL SCHEDULING REQUEST*****

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