



CANCER INSTITUTE

Wayne State University

Radiology Appointment Request

To request an appointment for your patient, fax completed form to 313-576-8240 or email returnpt@karmanos.org.

Please call 1-800-527-6266 for questions.

Today's Date: _____

PLEASE ATTACH PATIENT RX/REFERRAL WITH APPOINTMENT REQUEST

Referring Physician Information

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Office Contact Phone #: _____ Fax #: _____

Contact Patient Directly: Yes: _____ No: _____ Authorization Number: _____

Patient Information

Demographic sheet attached: Yes _____ No _____ (if no, please complete entire form)

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____

Insurance: _____ Policy #: _____ Group #: _____ Customer Svc. #: _____

BCCCP Enrollment Date: _____

Preferred Patient Phone #: _____ Alternate Phone #: _____ Best time to Call: _____ AM PM

Contact Person if not patient: _____ Relationship: _____ Phone #: _____

Referral Information: Location – Detroit: _____ Farmington Hills: _____

PET/CT (only available at Farmington Hills) CAT Scan MRI Ultrasound

Annual Mammogram Diagnostic Bilateral Mammogram Diagnostic Left Breast Diagnostic Right Breast

General X-ray

Appointment Time - Morning: _____ Afternoon: _____ 1st Available: _____

Reason for Diagnostic Exam? _____

Date & Location of previous mammogram: _____

History of breast cancer? Yes: _____ No: _____ Does patient have breast implants? Yes: _____ No: _____

Does patient have special needs (use walker, cane or wheelchair)? Yes: _____ No: _____

Interpreter needed? Yes _____ No: _____ Please specify language: _____

Comments: _____