MEDICAL APPOINTMENT SOLUTIONS

SENTARA

☐ **MRI** ☐ **CT** ☐ Schedule Appointment ☐ Obtain Authorization Phone: (757) 388-5768 Fax: (757) 233-4067

First Colonial Road AIC .....Tel: 757-395-6655
Leigh AIC .....Tel: 757-961-6800
Wainwright AIC .....Tel: 757-388-1920

Greenbrier Diagnostic Center .....Tel: 757-282-4025
Sentara Princess Anne .....Tel: 757-507-0100
Sentara Heart Hospital AIC .....Tel: 757-388-8870

Sentara Leigh Hospital .....Tel: 757-388-5768
Sentara Bayside Hospital .....Tel: 757-388-5768
Sentara VA Beach General Hospital .....Tel: 757-388-5768
Sentara Norfolk General Hospital .....Tel: 757-388-5768

PATIENT INFORMATION

Last Name: _____ First Name: _____

Social Security Number: _____

Date of Birth: _____ Sex: _____ Weight: _____

Home Phone Number: _____

Work Phone Number: _____

Cell Phone Number: _____

PREFERRED APPOINTMENT TIME

First Available Patient Preferred Date/Time & Location _____

PHYSICIAN INFORMATION

Referring Physician: _____

Location: _____

Office Contact: _____

Phone Number: _____

Fax Number: _____

Area to be examined (please be specific): _____

Reason for exam/pertinent clinical findings: _____

Additional findings: _____

Special requests: _____

CLINICAL HISTORY NEEDED FOR ORTHOPEDIC AUTHORIZATION PURPOSES (Check all services that have been provided)

Injury: Yes No If yes, DOI: _____ & what kind: _____

☐ X-rays
☐ Ultrasound
☐ Home exercises
☐ Work restrictions: If yes, how long? _____
☐ Assistive device
☐ Anti-inflammatory medicine
☐ Pain medication, specify: _____
☐ Antibiotics, specify: _____
☐ Steroid injections: how many times: _____
☐ Physical therapy, visits or duration: _____
☐ ICD Code: _____

Insurance Plan: _____

ID Number: _____

Group Number: _____

WC: Claim Number: _____ Contact Number: _____ Phone Number: _____

☐ **CONFIRMATION** MD Fax Number: _____

Appointment Date: _____ Time: _____ Location: _____

Authorization Number: _____

PHYSICIAN SIGNATURE AND DATE

X _____

WHITE: CLINIC **YELLOW: PATIENT** **PINK: PHYSICIAN**