DT18123

Children's℠ Healthcare of Atlanta

Interventional Radiology

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

☐ **Arthur M. Blank**
2220 North Druid Hills RD NE
Atlanta, GA 30329
404-785-0122
FAX: 404-785-9040

☐ **Scottish Rite**
1001 Johnson Ferry Road
Atlanta, GA 30342
404-785-0122
FAX: 404-785-9040

IR Email: IR@Choa.org

ALL AREAS BELOW IN BOLD ARE REQUIRED

Patient's FULL LEGAL Name	**Date of Birth**	**Phone Number**
Address	**City, State**	**ZIP**
Insurance/Medicaid Plan	**Policy & Group#**	
Authorization# *(Please also fax a copy of insurance card, front and back, with this order)*	Guarantor's Email	
Reason For Exam ***(Signs, Symptoms, Chief Complaint)***		
Exam to be Completed ***(If procedure is a Lumbar Puncture, Please notate below if opening/closing pressures are necessary along with CSF samples or CSF samples alone.)***		
Lab Orders ***(If any specimens are to go to the lab, please place Lab Orders below. If this section is not completed, no studies will be completed by the lab.)***		

ALL OFFICE CONTACT INFORMATION REQUESTED IS MANDATORY

Ordering Physician's Printed Name	**Practice Name**	
Ordering Physician's Signature	**Office Contact**	
Date/Time Signed	**Backline Phone**	**Fax**
PCP Name (if different):	**PCP Fax**	

Interventional Radiology

Special Instructions	**Order Comments / Other**
Date / Time Req: _____ Confirmed Appt: _____ Foster Child: ❑ Yes Contact: _____	