Children's Mercy

Radiology Scheduling
Phone: (816) 234-3272
Toll Free Phone: (800) 800-7300
Fax: (816) 802-1422

Patient Information:

Last:_____ First: _____ Middle: _____
DOB: ____/____/____ Gender: _____

Parent/Guardian Information: Last: _____ First: _____

Email: _____ Preferred Phone: _____ Alt Phone: _____
Relationship: _____ Preferred Language (if not English): _____

Diagnostic Testing

☐ X-Ray(s): _____

☐ US: _____

☐ Fluoroscopy: _____

☐ Dexa Scan _____

***Requires Prior Authorization prior to referral**

Prior Authorization #: _____

☐ CT*: _____
☐ w/ contrast ☐ w/out contrast
_____
☐ w/ contrast ☐ w/out contrast

☐ MRI*: _____
☐ w/out contrast ☐ w/ & w/out contrast
_____
☐ w/out contrast ☐ w/ & w/ out contrast

For MRI only: Is there metal in the patient's body or an implanted device?

☐ No ☐ Yes: _____

☐ Nuclear Medicine* _____

Diagnostic Testing Urgency:
☐ Urgent ☐ Routine

Preferred Location (if available):

Missouri: ☐ Independence ☐ Kansas City ☐ Northland (KC)
Kansas: ☐ Overland Park

Referring Provider Name: _____ NPI (if new referring provider): _____
Practice Name: _____ Call with acute findings only: ☐ Yes ☐ No

Office Phone: _____ **Office Fax:** _____

Primary Care Provider: ☐ Same as above Name: _____

Signature: _____ **Date:** _____