CenterLine Imaging Consultants
23772 West Rd, Suite #235
Brownstown Township, MI 48183
Phone: 586-899-1499 Fax: 586-992-4042

Diagnostic Imaging Interpretation Requisition Form

Patient Information

Patient Name: _____ Clinic Patient ID #: _____

Date of Birth: _____/_____/_____ Age: _____ Sex:_____

Study Submitted (please circle): Radiograph MRI or CT Comparison Study Other

Region of Study: _____ # of x-ray views: _____

Specific Location of Symptoms: _____ Date of onset: _____

History of Trauma or Surgery? _____ If YES, please describe: _____

_____

Indication for Study, Clinical History, Symptoms, Pertinent exam findings, or Special Concerns: _____

_____

_____

Any previous imaging studies performed of this area? _____

Patient History of any of the following?

☐ Diabetes Is this condition Well Managed or Poorly Managed? _____

☐ Smoking _____ Packs/Week _____ Duration in years

☐ Cancer Primary _____ Date of diagnosis_____

Known metastasis & location: _____

Images Sent: ☐ Images submitted as hard copies of plain films
☐ Images submitted on a disk

Image Return: ☐ Images are copies, which do not need to be returned
☐ Images are originals and should be returned

☐ Phone consultation is requested. Phone #: _____

The final signed report will be uploaded to LaraRad.
_____ Please initial here if you would prefer the report to be mailed to your billing address.

Referring Doctor Information

Doctor Signature: _____ Date: _____

Doctor Name: _____ Clinic: _____

Billing Address: _____

Phone #: _____ Fax #: _____

e-mail: _____

Payment Information

☐ Payment is included (checks may be made out to “CenterLine Imaging Consultants” or “CLIC”)

☐ Please send an invoice to

☐ Clinic billing address above

☐ e-mail address above

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Patient Consent for Release of Medical Records, Publication, and Research

CenterLine Imaging Consultants (CLIC) is committed to protecting your privacy and securing your medical information. We are required by federal law to maintain all Protected Health Information (PHI) that identifies you or could be used to identify you.

Under certain circumstances, we may disclose your PHI to researchers when their research has been approved by an Institutional Review Board (IRB). The IRB is responsible for reviewing any research proposals and establishing, with the researcher, protocols to ensure the privacy of your PHI. Whenever possible, research will be restricted to non-protected PHI data. Any PHI that is obtained will not be published.

You have the right to request restriction of your PHI, by asking us not to use or disclose any part of your PHI for purposes of research or publication. If you would like to make such a request, please submit a written request stating the restrictions which you would like to apply to you.

Patient Consent: Please initial the statements below and sign at the bottom of the consent form

_____ I hereby give my consent for release of my medical records, diagnostic imaging, or other clinical information related to my case to be utilized by the radiologists of CLIC for the purposes of interpretation, review, or facilitation of case management.

_____ I hereby give my consent for images or other clinical information related to my case to be utilized by the radiologists of CLIC for the purposes of publication or research.

I understand that my name, initials, or any other PHI, such as my patient ID number, billing information, address, phone number, etc *will not* be published. I understand that every attempt will be made to conceal my identity, but anonymity cannot be guaranteed. Images, such as diagnostic imaging, clinical presentations, or distinctive superficial body markings may be published. A good faith effort will be utilized to conceal my identity and remove any identifiable characteristics, name, dates, locations, etc. from any images. I understand that, through journal publication, research data or images collected may be viewed by the general public and via website, as the majority of scientific journals are published worldwide. I recognize that the information gathered may be used in full or in part in other publications licensed by the journal. This may include publication in print, electronic formats, or other formats utilized by journals now or in the future. This information will not be used for advertising, packaging, or out of context of this scholarly pursuit. I understand that I may revoke my consent at any time prior to publication, however once the information has been committed to publication, it will not be possible to revoke the consent.

_____ _____

Signature of patient (Signature of person giving consent on behalf of the patient) Date

_____

Name of patient (print)

If you are not the patient, but are giving permission for the patient, please complete the following section. Please note that the person giving consent should be a substitute decision maker, legal guardian, or hold power of attorney for the patient.

Why is the patient unable to give consent? (ie: patient is a minor, incapacitated, or deceased) _____

_____ _ _____

Name (print) Relationship to Patient
