Clinical Information Form

This form may be used to initiate a RadConsult process.
Upon completion, please fax this form to HealthHelp at
877-883-5684.

Date:		Time:	
Member Name:		Member ID Number:	
Member DOB:			
Referring Physician Information (The physician who is ordering the exam)		**Rendering Provider Information (Where the service will be provided)**	
Provider Name: Last: First:		***Name of Facility:***	
Phone: ( ) Fax: ( )		Phone: ( ) Fax: ( )	
Contact Name: Contact Phone Number:			
Procedure Information (please include CPT Code)			
Date of Procedure (if known):		Procedure:	
Date of Procedure (if known):		Procedure:	
Date of Procedure (if known):		Procedure:	
Clinical Information (all must be completed)			
1. Patient's diagnosis or symptoms (include duration, frequency, and intensity):			
2. What is the physician suspecting or ruling out with the requested study?			
3. Has the patient received treatment for the above symptoms (include duration and type)?			
4. List any previous relevant testing (i.e. labs, diagnostic imaging, or other test), include results:			
5. Is study part of a standard post-chemo/radiation protocol in a patient with a prior cancer diagnosis? **(Circle one) Yes No**			
Cancer type:			

***Please attach any additional relevant clinical information*

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