GUAM REGIONAL MEDICAL CITY
Where Patients are Partners

RADIOLOGY REFERRAL FORM

133 Route 3 I Dededo, GU 96929
PH: (671) 633-GRMC (4762)
FAX: (671) 969-4874
EMAIL: refer@grmc.gu

PATIENT INFORMATION

NAME: ______________________ DOB: __________
CONTACT #: ______________________ INSURANCE: __________
EMAIL ADDRESS: ______________________

REFERRAL INFORMATION

REFERRRING PHYSICIAN: ______________________ ORGANIZATION __________
PHONE# ______________________ FAX#: __________
EMAIL ADDRESS: ______________________

Referral Priority: ○ Routine: (next available date) ○ Urgent (less than 48 hours) ○ STAT (Immediately)

HISTORY/REASON FOR REFERRAL: ______________________

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EXAM REQUESTED:

CT SCAN ______________________ ○ WITH & WITHOUT ○ NON-CONTRAST
MRI ______________________ ○ WITH & WITHOUT ○ NON-CONTRAST
ULTRASOUND ______________________ ○ BIOPSY ______________________
X-RAY ______________________ ○ FLUOROSCOPY ______________________
INTERVENTIONAL RADIOLOGY ______________________

PREPARATION:

○ None ○ Fasting 6-8 hours ○ No Blood Thinner
○ Full Bladder (Drink 6-8 glasses of water)
○ Laboratory Test (Bun, Creatine, and GFR)
Completed at: ______________________ When: ______________________
○ Laboratory Test for Biopsies or any Procedure
PT/PTT, INR, BMP, CBC with Platelets)
Completed at: ______________________ When: ______________________
○ Prior Exams Related to the Exam? ○ YES ○ NO
Please have patient bring a copy of all prior exams to their appointment
○ Pre-Certifications Submitted? ○ YES ○ NO
When: ______________________ ○ No Pre-Certifications is Required

NOTES:

REFERRING PHYSICIAN SIGNATURE: ______________________ DATE: __________