

SUBMIT: H&P, KUB, AND ONE OR MORE OF THE FOLLOWING: IVP, CT, U/S
TO AVOID DELAYS IN PROCESSING, ALL INFORMATION IS REQUIRED

X-RAY EVALUATION FORM

DATE: _____

REFERRING PHYSICIAN: _____ PHONE: _____ FAX: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

LAST FIRST MI

PATIENT SOCIAL SECURITY # _____

ADDRESS: _____

STREET CITY STATE ZIP

TELEPHONE NUMBERS _____

HOME WORK

INSURANCE CARRIER/PROVIDER _____ POLICY # _____

(Please provide a current copy of insurance card)

REFERRING PHYSICIAN TO COMPLETE

H P I (symptoms and procedures - e.g. stent) _____

P M H + ANESTHETIC RISK FACTORS _____

MEDICATIONS _____

Stone Sizes (mm)

height width

- | | | | |
|----|-------|---|-------|
| 1. | _____ | x | _____ |
| 2. | _____ | x | _____ |
| 3. | _____ | x | _____ |

KIDNEY STONE CENTER USE ONLY

___ **NEW** ___ **RETREAT** ___ **STAGED**

KIDNEY STONE CENTER EVALUATION:

