DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

IMAGING QUESTIONNAIRE

(MRI, CT, PET or PET/CT imaging equipment only)

Reporting Period: (*Please provide data for* **Calendar Year 2010** *)*

(Imaging equipment, utilization and health care services provided are for this physical location only – if another campus or satellite imaging office is owned and operated by the same provider in a different town, complete an additional questionnaire for that location – e.g., Helen and Harry Gray Cancer Center in Avon should be completed on a separate questionnaire from Hartford Hospital)

1) Provider Name:_____

2) Service Address:_____

3) Service City:_____ **CT** **4) Service Zip Code:**_____

5) Date Completed:_____ **6) Contact Name:**_____

7) Contact Title:_____ **8) Contact Phone:**_____

9) Contact Fax:_____ **10) Contact Email:**_____

(Please list name and contact information for provider)

11) Provider Type: Hospital ☐ Imaging Center ☐ Physician's Office ☐

Other:_____

(Please check appropriate box or list alternative provider type where MRI, CT, PET or PET/CT is used)

12) Hours of Operation: Day(s):_____ From:_____ To:_____

Day(s):_____ From:_____ To:_____

Day(s):_____ From:_____ To:_____

(Please list hours of operation for provider – e.g., M-F 8am to 5pm)

13) Average wait time from appointment request to appointment date for each modality at this location:

MRI _____*day(s)* ***CT***_____ *day(s)* ***PET***_____ *day(s)* ***PET/CT*** _____ *day(s)*

14) Equipment/Volumes:

(Please list the individual imaging equipment (MRI, CT, PET or PET/CT only) located at this location as of 12/31/10, a brief description of the equipment, department in hospital or other multi-department provider, the number of patients treated and the number of scans (one scan = one single CPT coded procedure) for the calendar year 2010)

Equipment (MRI, CT, PET, or PET/CT as of 12/31/10)	**Equipment Description** (Fixed or Mobile, Model, Open or Closed, Tesla, #of Slices, etc.)	**Department** (ED, Radiology, Cancer Ctr., etc.)	**# Of Patients Treated CY 10**	**# Of Scans CY 10**

Total				

15) Primary Payer Source *(Please list patient's primary payer source)*

Payer Source	# Of Patients Treated CY 10
Commercial	
Medicare	
Medicaid	
Other Government	
Uninsured	
Total	

16) Clinical Staff *(Please list the type and number of clinical staff members at your location as of 12/31/10)*

Clinical Staff	# of Staff
Radiologists	
Radiology Technicians	

PLEASE COMPLETE AND RETURN QUESTIONAIRE BY XX/XX/XXXX

If you have any questions pertaining to this questionnaire, please contact:

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Or

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