

**RADIOLOGY ORDER FORM**

Patient Name (Last): \_\_\_\_\_ (First): \_\_\_\_\_

Patient Address: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Race \_\_\_\_\_ Ethnicity \_\_\_\_\_

Phone (Home): \_\_\_\_\_ [Cell]: \_\_\_\_\_

Ordering Physician: \_\_\_\_\_ Clinical History: \_\_\_\_\_

ICD10 Code: \_\_\_\_\_ Need by Date: \_\_\_\_\_

Allergies: \_\_\_\_\_ Diabetic:  Y  N Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Please fax copy of insurance card and authorization with order.** OCSRI-NPI 1962876045

Insurance Company: \_\_\_\_\_ Policy ID #: \_\_\_\_\_

Authorization #: \_\_\_\_\_

\* If Medicaid authorization applies to imaging services, authorization must include TC and 26 Modifiers.

\_\_\_\_\_

Report only to office       CD with report only to office       Patient to hand-carry films

HOLD AND CALL REPORT      Call Report #: \_\_\_\_\_      Fax Report #: \_\_\_\_\_

**CT**

**HEAD/NECK**

- w w/o
- Brain
  - Sinuses
  - Temporal Bones/IAC
  - Orbits
  - Facial Bones
  - Neck Soft Tissue

**CHEST**

- w w/o
- Chest
  - CTA Chest for PE

**SPINE**

- w w/o
- Cervical Spine
  - Thoracic Spine
  - Lumbar Spine

**ABD/PELVIS**

- w w/o
- Abdomen & Pelvis
  - Renal Stone (ABD/Pelvis w/o)
  - Abdomen Only
  - Pelvis Only
  - Other \_\_\_\_\_

**NUCLEAR MEDICINE**

**BONE SCAN**

- Whole Body
- Multiple Specific Area
  - 3-Phase
- Liver/Spleen Scan
- Hepatobiliary (HIDA)
  - CCK Ejection Fraction:
    - w  w/o
- Cardiac MUGA Scan
- Indium WBC Scan
- Parathyroid Scan
- Thyroid Uptake and Scan
- I-131 Whole Body Scan
- Renal Scan
  - Flow and Function
- Other \_\_\_\_\_

**PET/CT**

- Eyes to Thigh
- Whole Body

**PET/CT (CONTINUED)**

- PET Pylarify for Prostate
- PET Other (limited)
- PET Dotatate for Neuroendocrine Tumors

**ULTRASOUND**

- Gallbladder / Liver (RUQ)
- Abdomen complete
- Renal / Kidney (incl. Bladder)
- Pelvic (w/ Endovag if indicated)
- Endovaginal only
- Thyroid / Neck
- Thyroid / Biopsy
- Testicular / Scrotum (including Doppler)
- Carotid Doppler
- Extremity: Venus Doppler
  - L  R  Upper  Lower
- Other \_\_\_\_\_

**MRI**

**HEAD/NECK**

- w w/o
- Brain
  - Orbit
  - Face
  - Neck
  - TMJ

**SPINE**

- w w/o
- Cervical Spine
  - Thoracic Spine
  - Lumbar Spine
  - Sacrum

**BODY**

- w w/o
- Chest
  - Abdomen  MRCP
  - Pelvis
  - Extremity  L  R
    - Area of interest  L  R
  - Extremity Joint
    - Area of Interest \_\_\_\_\_
  - Other \_\_\_\_\_

**RADIOGRAPHY (PLAIN FILMS)**

**THORAX**

- Chest PA and Lateral
- Decub Chest  L  R
- Ribs  L  R  Bilat

**ABDOMEN**

- KUB
- Flat & Upright (Obstruct. Series)
- Acute Abd Series (include PA Chest)
- Decub Abdomen
  - L  R  Bilat

**HEAD**

- Facial Bones
- Sinus Limited (Waters view)
- Sinus

**EXTREMITIES/PELVIS**

- Fingers: spec \_\_\_\_\_
- Hand  L  R
- Wrist  L  R
- Forearm  L  R
- Elbow  L  R
- Humerus  L  R
- Clavicle  L  R
- Shoulder  L  R
- Toes: spec \_\_\_\_\_
- Foot  L  R
- Calcaneous  L  R
- Ankle  L  R
- Tibia/Fibula  L  R
- Knee  L  R
- Standing Knee  L  R
- Femur  L  R
- Hip  L  R
- Pelvis  R
- Other \_\_\_\_\_

**INTERVENTIONAL RADIOLOGY**

(please send patient for INR — cannot be older than 2 weeks)

- Port Placement  Thoracentesis
- Port Removal  Paracentesis
- PICC Line  Kypho/Vert Aug (spine) Level \_\_\_\_\_
- G Tube Placement  RFA spine Level \_\_\_\_\_
- Pleurex Catheter-pleural  Other \_\_\_\_\_
- Pleurex Catheter-peritoneal  Other \_\_\_\_\_

\*PET Pylarify and PET Dotatate will require supporting documentatiuon (physician notes, labs, ie PSA) to verify criteria has been met for imaging.

Physician Signature \_\_\_\_\_ Physician Printed Name \_\_\_\_\_

Physician Address (if CD is to be mailed) \_\_\_\_\_

Physician Office Phone Number \_\_\_\_\_