Diagnostic Imaging Order Form

212 Willie Ray Dr. Cabot, AR 72023 • Phone: (501) 333-9110 • Fax: (501) 333-9120

Required Information

Name: _____ **Date of Birth:** ___/___/___ **Weight:** _____ lb / kg

Insurance: _____ **Pre-Auth#/Date Range:** _____

Ordering Physician: _____ **Phone:** _____

Physician Signature: _____ **NPI #:** _____ **Date:** _____

Clinical Reason for Exam (ICD 10 codes): _____ **CPT Code(s):** _____

Physician Preference for Results: ☐ Routine ☐ Urgent ☐ STAT **Fax:** _____

Notes: _____

MRI

Contrast: ☐ wo ☐ w/wo ☐ per protocol

☐ **Brain**
- O Pituitary
- O IAC's
- O Seizure
- O MS
- O Tumor Eval

☐ Orbits
☐ Maxillofacial
☐ Neck Soft Tissue

—Spine—

☐ Cervical
☐ Thoracic
☐ Lumbar
☐ Sacrum/Coccyx

—Vascular—

☐ MRA Brain
☐ MRA Neck & Arch

—Ortho—

☐ Upper Extremity *(please specify)*

_____

☐ Lower Extremity *(please specify)*

_____

—Body—

☐ Chest
☐ Abdomen
☐ MRCP
☐ Pelvis

Other_____

CT

Contrast: ☐ wo ☐ w ☐ w/wo ☐ per protocol

☐ Brain
☐ Sinus/Facial Bones
☐ Soft Tissue Neck
☐ Spine C T L
☐ Chest
☐ Abdomen/Pelvis
☐ Renal Stone
☐ Urogram w/wo
☐ Adrenal Washout w/wo
☐ Bony Pelvis
☐ Upper/Lower Extremity *(please specify)*

_____

——CT Angio ——

☐ Brain w/
☐ Neck w/
☐ Abdomen/Pelvis w/
☐ Renal w/

☐ Chest w/
- O Aorta
- O PE

Other_____

Ultrasound

☐ Abdomen
☐ Pelvis/Doppler
☐ Renal/Bladder
☐ Testicular
☐ Bladder
☐ Prostate
☐ Breast R L
☐ Pelvis w/ endo vaginal
- O w/o endo vaginal

☐ Thyroid
☐ OB US: O Complete O Early O Limited
- O 3D/4D O Biophysical Profile

—Vascular—

☐ Carotids
☐ Arterial Doppler
- O Upper R L
- O Lower R L

☐ Venous Doppler
- O Upper R L
- O Lower R L

Other_____

Digital X-Ray

☐ Skull
☐ Nasal
☐ Chest
☐ Abdominal Series
☐ Cervical
☐ Thoracic
☐ Lumbar
☐ Ribs R L
☐ Shoulder R L

☐ Clavicle R L
☐ Humerus R L
☐ Elbow R L
☐ Forearm R L
☐ Wrist R L
☐ Hand R L
☐ Femur R L
☐ Knee R L

☐ Tib/Fib R L
☐ Sacrum+Coccyx
☐ SI Joints
☐ TMJ R L
☐ Pelvis
☐ Finger R L 1 2 3 4 5

☐ Ankle R L
☐ Foot R L
☐ Calcaneus R L
☐ Toes R L
☐ Hip R L

Other_____

This form must be completed, signed by a physician, and presented to the Cabot Emergency Hospital registration desk prior to any test being performed. Thank you!

Precertification Checklist

(Please do not complete this section)

☐ Copy of Insurance Card *(front & back)* ☐ Most Recent H&P ☐ Ordering Physician's NPI ☐ Patient Demographics

Appointment Date & Time: _____

Prep Instructions Given: ☐ Yes (Specify): _____ ☐ No ☐ N/A