CABOT EMERGENCY HOSPITAL

DIAGNOSTIC IMAGING ORDER FORM

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

PATIENT INFORMATION

Name: ______________________ **Date of Birth:** ___/___/___ **Weight:** ________lbs **Phone:**______________

Insurance/Policy #: ______________________ **Pre-Authorized #/Date Range:** ______________________

Ordering Physician (Please Print): ______________________ **Phone:** ______________

Physician Signature: ______________________ **NPI#:** ______________ **Date:** ______________

Clinical Reason for Exam (ICD 10 Codes): ______________________ **CPT Code(s):** ______________________

Physician Reference for Results: ☐ **Routine** ☐ **Urgent** ☐ **STAT** ☐ **Fax:** ______________________

Notes: ____

MRI

Contrast: ☐ **W/O** ☐ **W & WO**

- ☐ Brain
  - ☐ Pituitary
  - ☐ IAC's
  - ☐ Seizure
  - ☐ MS
  - ☐ Tumor Eval
- ☐ Orbits
- ☐ Maxillofacial
- ☐ Neck Soft Tissue

• SPINE •

- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar
- ☐ Sacrum/ Coccyx

• VASCULAR •

- ☐ MRA Brain (WO Contrast Only)
- ☐ MRA Neck & Arch (WO Contrast Only)

• ORTHO •

- ☐ Upper Extremity (Specify): ______________________
- ☐ Lower Extremity (Specify): ______________________

• BODY •

- ☐ Abdomen (WO Contrast Only)
- ☐ MRCP
- ☐ Pelvis

☐ Other: ______________________

CT SCAN

Contrast: ☐ **W** ☐ **W/O** ☐ **W & WO**

- ☐ 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 (Specify): ______________________

• CT ANGIO •

- ☐ Brain W/
- ☐ Neck W/
- ☐ Abdomen/ Pelvis W/
- ☐ Renal W/
- ☐ Chest W/
  - ☐ Aorta
  - ☐ PE
- ☐ Other: ______________________

ULTRASOUND

- ☐ Abdomen Complete
- ☐ Abdomen Limited
- ☐ Pelvis/ Doppler
- ☐ Renal/ Bladder
- ☐ Testicular
- ☐ Bladder
- ☐ Prostate
- ☐ Breast
- ☐ Pelvis W/ Endo Vaginal
  - ☐ WO Endo Vaginal
- ☐ Thyroid
- ☐ OB US:
  - ☐ Complete
  - ☐ Early
  - ☐ Limited
  - ☐ 3D/ 4D
  - ☐ Biophysical Profile

• VASCULAR •

- ☐ Catoids
- ☐ Arterial Doppler
  - ☐ Upper R L
  - ☐ Lower R L
- ☐ Venous Doppler
  - ☐ Upper R L
  - ☐ 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
- ☐ Ankle R L
- ☐ Foot R L
- ☐ Calcaneus R L
- ☐ Toes R L
- ☐ Hip R L
- ☐ Finger R L 1 2 3 4 5

☐ 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!