

Patient Name: _____ Last _____ First _____ MI _____ DOB: _____ Home Phone: _____
 Patient Insurance: _____ Authorization #: _____ Daytime Phone: _____
 Medical Necessity (Required): _____
 Appointment Date/Time: _____
 (Must include pertinent clinical history. "Rule out or suspected" diagnosis alone is not sufficient.)



PET/CT

- Brain PET/CT _____
- Cardiac Viability PET/CT _____
- Oncology PET/CT _____
- PET/CT & a Diagnostic CT _____
- neck, chest, abdomen,
& pelvis CT with contrast.
- Diagnosis _____
- Initial Staging _____
- Response to Therapy _____
- Restaging _____
- Cancer Type _____

CT

- Head _____
- Soft Tissue Neck _____
- Sinus _____
- Chest _____
- PE Study (Chest) _____
- High Resolution Chest _____
- Abdomen/Pelvis _____
- Renal Stone Protocol _____
- Appendicitis Protocol _____
- Abdomen _____
- Pancreas Protocol(Abdomen) _____
- Pelvis _____
- Extremity RT LT _____
- specify: _____
- CT Spine w/o contrast _____
- __CSP __TSP __LSP
- CT w/ Intrathecal contrast _____
- __CSP __TSP __LSP
- CT Colonography _____
- CT Enterography _____
- CT Urogram _____
- CTA-----
- Brain (Circle of Willis) _____
- Carotid _____
- Renal _____
- Runoff _____
- Chest _____
- Chest/Abdomen _____
- Chest/Abdomen/Pelvis _____
- Pre-op AAA Stent Protocol _____
- Post-op AAA Stent Protocol _____
- Other _____

MRI

- Brain _____
- Breast w/CAD review _____
- MRI-Guided Breast Biopsy _____
- IAC _____
- Pituitary _____
- Orbit _____
- Liver _____
- Renal MR/MRA _____
- Adrenal _____
- MRCP _____
- C-Spine _____
- T-Spine _____
- L-Spine _____
- Pelvis - Bone _____
- Pelvis - Oncology _____
- Neck (soft tissue) _____
- Knee RT LT _____
- Hip RT LT _____
- Shoulder RT LT _____
- Ankle RT LT _____
- Foot RT LT _____
- Wrist RT LT _____
- Elbow RT LT _____
- MRA _____
- __COW _____
- __Carotid _____
- __Aorta _____
- __Renal _____
- __Runoff _____
- MRV _____
- MR Arthrogram _____
- Area _____
- Other _____

Ultrasound

- Abdomen Complete _____
- Abdomen Limited - Rt Upper _____
- Abdomen Aorta _____
- Bladder _____
- Carotid _____
- Follicle Study - Transvaginal _____
- OB _____
- __Follow-up _____
- __Transvaginal _____
- __Biophysical Profile _____
- __Umbilical Cord Doppler _____
- __Pelvis / Transvaginal w/doppler _____
- as deemed necessary by radiologist
- Renal _____
- Renal Artery Doppler _____
- Sonohysterogram _____
- Testicular with doppler as deemed _____
- necessary by radiologist
- Thyroid _____
- Thyroid Biopsy _____
- Venous Leg (DVT) RT LT BI _____
- Other: _____

For breast, use Diagnostic Breast Evaluation section

XRay

- __Type _____

DEXA Bone Densitometry

- __DEXA (Osteoporosis Evaluation)

Interventional

- Lumbar Epidural Steroid _____
- Injection _____
- Facet Injection _____
- Level _____
- Joint Injection _____
- __SI _____
- __Hip _____
- __Shoulder _____
- __Ankle _____
- __Wrist _____
- __Other _____
- Catheter Injection _____
- Arthrogram _____
- Paracentesis _____
- Thoracentesis _____
- Lumbar Puncture _____
- Labs _____

Screening Mammogram

- Screening with CAD review _____
- (No history needed)

Diagnostic Breast Evaluation

Mammogram with CAD review, Breast Ultrasound and Biopsy as deemed necessary by radiologist. If your patient is due for annual screening, both breasts will be imaged.

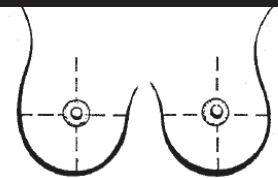
- Diagnostic RT LT BI _____
- Medical necessity:
- __Palpable abnormality _____
- __Noncyclic focal pain _____
- or tenderness _____
- __Nipple discharge (circle one) _____
- Bloody Clear Cloudy _____
- __Induration / skin changes _____
- __Axillary adenopathy _____
- __Current treatment/Breast CA _____
- __Breast implant problems _____
- __Other _____

- Ultrasound RT LT BI _____

- Add Views RT LT BI _____
- (abnormal mammogram)
- 6 mo. follow-up RT LT BI _____
- __abnormal mammogram _____
- __abnormal ultrasound _____
- __palpable abnormality _____
- __breast cancer _____
- __other _____

Breast MRI w/CAD review

Area of Concern



Breast Biopsy / Localization

- Breast Biopsy RT LT BI _____
- Needle Localization RT LT BI _____
- Cyst Aspiration RT LT BI _____

Medical necessity:

- __Abnormal Mammogram _____
- __Abnormal MRI _____
- __Abnormal Ultrasound _____
- __Palpable abnormality _____
- (Mark on diagram)
- __Other _____

Reporting: Standard STAT Keep patient / Call Results to: _____ Phone: _____
 Send Images Fax Results to: _____

Physician (Please Print) _____

Physician Signature (Required) _____

Date _____