

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 _____
- CT Arthrogram _____
- Area _____
- 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 _____

Venous Insufficiency Consultation

- ___ Vein Screening, physician consultation and necessary treatment including endovenous laser ablation.
- ___ Right _____
- ___ Left _____
- ___ Bilateral _____
- Diagnosis: _____
- ___ Venous Insufficiency _____
- ___ Venous Ulcers _____
- ___ Varicose Veins _____
- ___ Leg Pain _____
- ___ Other _____
- ___ 1 month follow-up _____
- ___ 5 day follow-up _____

Ultrasound

- Abdomen Complete _____
- Abdomen Limited - Rt Upper _____
- Abdomen Aorta _____
- Bladder _____
- Carotid _____
- Follicle Study - Transvaginal _____
- OB _____
- ___ Anatomical Survey _____
- ___ 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 _____
- Venous Arm (DVT) RT _____ LT _____ BI _____
- Arterial Leg RT _____ LT _____ BI _____
- Other: _____

For breast, use Diagnostic Breast Evaluation section

XR

- ___ 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.

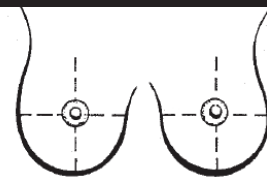
- ___ Diagnostic RT _____ LT _____ BI _____
- Medical necessity: _____
- ___ Palpable abnormality _____
- ___ Noncyclic focal pain or tenderness _____
- ___ Nipple discharge (circle one) _____
- ___ Bloody _____ Clear _____ Cloudy _____
- ___ Induration / skin changes _____
- ___ Axillary adenopathy _____
- ___ 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 _____ 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 _____
- ___ Ductogram 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 _____