

Patient Name: _____ DOB: _____ Contact #: _____
Last First MI

Patient Insurance: _____ Authorization#: _____ Appt Date/Time: _____

Medical Necessity (Required): _____

(Must include pertinent clinical history. "Rule out or suspected" diagnosis alone is not sufficient.)

The referring provider must request authorization from the patient's insurance, if required. Please attach a copy of the authorization for all CT, MRI, and PET scans when faxing the order to us. Thanks you!

PET/CT

___ Brain PET/CT ☐ Amyloid or ☐ FDG
___ Cardiac Viability PET/CT
___ Oncology PET/CT
___ Neuroendocrine PET/CT
___ Prostate PET/CT

NeuroQuant Imaging

☐ MRI w/o contrast NeuroQuant
T-code 0866T
Must select one
☐ Dementia
☐ MS
☐ Seizure

☐ MRI w & w/o contrast
NeuroQuant T-code 0866T
Must select one
☐ Dementia
☐ MS
☐ Seizure

Breast Imaging Studies

If your patient is due for annual screening, both breasts will be imaged.

___ **Screening Mammogram**
(No symptoms)

___ **Diagnostic Mammogram**
(Ultrasound, Biopsy as Needed)
___ Left ___ Right ___ Bilateral

___ Clinical Finding: _____
___ Add Views - abnormal mammo
___ 6 Month Follow-up

___ **Breast Ultrasound**
(Mammogram, Biopsy & Pathology as Needed)
___ Left ___ Right ___ Bilateral

Breast Biopsy / Localization

___ **Breast Biopsy (US or Stereo)**
(Mammogram, US & Pathology as Needed)
___ Left ___ Right ___ Bilateral

___ **Needle Localization**
(Mammogram, US as Needed)
___ Seed or ___ Wire
___ Left ___ Right ___ Bilateral

___ **Cyst Aspiration** (Labs as needed)
(Mammogram, US, Biopsy & Pathology as Needed)
___ Left ___ Right ___ Bilateral

___ **Ductogram**
(Mammogram, US, Biopsy & Pathology as Needed)
___ Left ___ Right ___ Bilateral

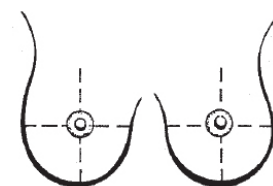
Targeted Studies

Following abnormal breast MRI:

___ **Targeted Breast Ultrasound**
(Mammogram, Biopsy & Pathology as Needed)
___ Left ___ Right ___ Bilateral

___ **Target Breast Additional Views**
(Ultrasound, Biopsy & Pathology as Needed)
___ Left ___ Right ___ Bilateral

Area of Concern



CT

I.V. CONTRAST

☐ WITH ☐ WITHOUT

___ Head
___ Soft Tissue Neck
___ Sinus
___ Chest
___ Lung Cancer Screening
___ PE Study (Chest CTA)
___ High Resolution Chest
___ Abdomen/Pelvis
___ Renal Stone
___ Appendicitis
___ Abdomen
___ Pancreas
___ Pelvis
Extremity RT LT ___
specify: _____

___ CT Spine w/o contrast
___ CSP ___ TSP ___ LSP

___ CT w/ Intrathecal contrast
___ CSP ___ TSP ___ LSP

___ CT Enterography
___ CT Urogram
___ CT Arthrogram
Area _____

-----CTA-----

___ Brain (Circle of Willis)
___ Carotid
___ Renal
___ Runoff
___ Chest
___ Abdomen
___ Pelvis
___ Pre-op AAA Stent
___ Post-op AAA Stent
___ 3D Post Processing
Other _____

DEXA Bone Densitometry

___ DEXA (Osteoporosis Evaluation)

MRI

I.V. CONTRAST

☐ WITHOUT
☐ WITH & WITHOUT
___ Brain
___ Breast w/CAD review
___ MRI-Guided Breast Biopsy
(Mammography and Pathology as Needed)
___ IAC
___ Pituitary
___ Orbit
___ Liver
___ Renal
___ Adrenal
___ MRCP
___ Prostate MRI w & WO (OnQ)
___ 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
___ Other _____
___ MRA
___ COW
___ Carotid
___ Aorta
___ Renal
___ Runoff
___ MRV
___ MR Arthrogram
Area _____
Other _____

Ultrasound

___ Abdomen Limited - Rt Upper Quadrant
___ Abdomen Complete
___ Abdomen Aorta
___ Bladder
___ Carotid
___ Follicle Study - Transvaginal
___ OB
___ Anatomical Survey
___ Follow-up
___ Transvaginal
___ Biophysical Profile
___ Umbilical Cord Doppler
___ Parotid biopsy and pathology
___ Pelvis / Transvaginal with doppler
as deemed necessary by radiologist
___ Renal w/Bladder
___ Renal Artery Doppler
___ Testicular with doppler as deemed
necessary by radiologist
___ Thyroid
___ Thyroid Biopsy/FNA & Pathology
___ Soft Tissue
___ Soft Tissue Biopsy & Pathology
___ Lymph Node Biopsy & Pathology
___ 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

Interventional

___ Lumbar Epidural Steroid
Injection
___ Facet Injection
Level _____
___ Joint Injection
___ SI
___ Hip
___ Shoulder
___ Ankle
___ Wrist
___ Other
___ Arthrogram
___ Lumbar Puncture
Labs _____

XRay

___ Type

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

Physician (Please Print)

Physician Signature (Required)

Date



Phone: 605-342-2852
 Fax: 605-721-8805
 www.dakota-radiology.com

Specialty	Indication	Recommended Imaging Exam
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Breast	New palpable lesion / Nipple discharge/ Focal pain	Diagnostic mammogram & US (if ≥ 30 y/o)
	Annual screening mammography ≥ 40 y/o	Screening Mammogram W/ Tomosynthesis
	Post lumpectomy – routine follow-up	Screening Mammogram W/ Tomosynthesis
	Breast cancer staging / High risk for breast cancer (≥20% lifetime risk of breast cancer)	Breast MRI W &W/O Contrast

Cardiopulmonary	Lung nodules follow-up (not from screening)	CT Chest W/O Contrast
	Abnormal CXR / Cough / Cancer / Pain / SOB	CT Chest W/ Contrast
	Pulmonary embolus	PE Study - Chest CTA W/Contrast
	Aorta aneurysm or dissection/ Arteritis	Chest CTA W/Contrast
	High risk lung cancer screening	Lung Cancer Screening CT W/O Contrast

Gastrointestinal	Pain / Bowel obstruction/ Tumor / Infection	CT Abd/Pelvis W/ Contrast
	Pancreatitis or Pseudocyst	
	Liver lesion / Cirrhosis / Hepatoma	MRI Abdomen W &W/O Contrast
	Abnormal CT Finding	(if initial RUQ pain —> ultrasound)
	Biliary pathology / Pancreatic / Mass	MRCP W &W/O Contrast
	Rectal cancer staging / Cervical or Uterine cancer	MRI Pelvis W &W/O Contrast

Genitourinary	Hematuria/ Bladder or Ureteral tumor	CT Urogram W & W/O Contrast
	Flank pain / Renal colic	CT Renal stone W/O Contrast
	Renal mass	Renal MRI W & W/O Contrast
Musculoskeletal	Osteomyelitis / Avascular necrosis	MRI W/O Contrast (for area of interest)
	Chronic pain / Ligamentous or Tendon injury	MRI W/O Contrast (for area of interest)
	Tumor/ Inflammatory arthritis / AVM	MRI W & W/O Contrast (for area of interest)
	Trauma / Fracture Follow-up	CT W/O Contrast (for area of interest)

Neuro Brain or Spine	Trauma/ Fracture / Acute mental status change	CT Head W/O Contrast
	Ischemia / Memory loss /Dizziness	MRI Brain W/O Contrast
	Infection / Tumor / Demyelination	MRI Brain W &W/O Contrast
	Seizures >30 y/o / Headache	
	Increased prolactin	MRI Pituitary W & W/O Contrast
	Sinus headache / Symptoms	CT Sinus W/O Contrast
	Hearing loss / Vertigo / Cranial nerve symptoms	MRI Internal Auditory Canal W & W/O Contrast
	Cerebellopontine angle tumor	Contrast
	Chronic back or neck pain / Radiculopathy	MRI Spine W/O Contrast

All Contrast exams: Patients over 60, diabetic or HTN will require a creatinine lab value within the last 60 days.
 Pregnant patients do not receive Gadolinium.

These are general guidelines. We are always available for expert consultation. 605-342-2852