WEST CANCER CENTER & RESEARCH INSTITUTE
partner of OneOncology

Radiology Scheduling
Fax: 901.322.2994
Phone: 901.609.3556

RADIOLOGY-PHYSICIAN ORDER FORM

All Fields Required

Patient Information

_____ _____ _____ Male ☐ Female ☐
(Last Name) (First Name) (M.I.)

_____ _____ _____ Contrast Allergy ☐ No ☐ Yes _____
(Phone Number) (SS#) DOB (MM-DD-YYYY) (What Type)

_____ _____ _____
(Address) (City, State, Zip) (Prior Studies/Date/Location)

Mandatory to schedule: list of current medications, pertinent H & P, Labs and Insurance Card

PATIENT APPOINTMENT DATE_____ **TIME**_____ **SCHEDULED BY** _____

_____ _____ _____ _____ _____
(Ordering Physician Name-Print) *(Ordering Physician Signature)* *(Order Date)* *(Contact Person)* *(All Reports Faxed To)*

Diagnosis/Symptoms Requiring Test (Indicate Medical Necessity and any clinical information clarifying each service being requested)
ICD 10: _____

_____

Diagnostic

CT SCAN	W	W/O	W & W/O
Head			
Chest			
Abdomen			
Pelvis			
Neck			
Screening Lung			
CTA	**W**	**W/O**	**W & W/O**
Head			
Neck			
Chest			
Abdomen			
CTA runoff (Legs)			
PET			
PET/CT - Skull Base to Mid Thigh			
MRI	**W**	**W/O**	**W & W/O**
Head			
Neck			
Abdomen			
Pelvis (Rectal) (Female) (Prostate) (Bone)			
Spine (C) (T) (L)			
MRA	**W**	**W/O**	**W & W/O**
Head/Neck (Order Both)			
ULTRASOUND			
Chest			
Abdomen			
Pelvis			
Legs			
Neck			
Thyroid			
Vascular Area			
Location			
OTHER			

Interventional

BIOPSIES	
Liver	
Lung	
Pancreas	
Abdominal/Pelvic	
Bone	
Thyroid	
Renal	
Node/Mass	
TEST NEEDED	
Histopath/SurgPath	
Molecular (Caris) (Foundation One)	
Flow Cytometry	
DRAINAGES	**Abscess Area**
Thoracentesis	
Paracentesis	
Ureteral Stent	
Biliary	
Gastrostomy	
Nephrostomy	
ANGIO/VENOGRAPHY	
Diagnostic/Local Region	
LINES	
PICC/Hickman	
PAC	
SVC Stent	
IVC Filter/ Removal	
VASCULAR BLAND INTERVENTION	
Chemo/Embolization	
Fibroid Embolization	
ABLATION	**Location**
Lung	
Liver	
Bone	
Kidney	
OTHER	