



# 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			
PET Netspot			
PET Axumin			
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**

<b>BIOPSIES</b>	
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	