WEST CANCER CENTER & RESEARCH INSTITUTE

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	☐		
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

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	