

## WEST CANCER CENTER & RESEARCH INSTITUTE: RADIOLOGY PHYSICIAN ORDER FORM

PATIENT INFORMATION: *(all fields are required)*

\_\_\_\_\_  
LAST NAME FIRST NAME M.I. MALE FEMALE

\_\_\_\_\_  
PHONE NUMBER SSN DOB (MM/DD/YYYY) CONTRAST ALLERGY IF SO, WHAT TYPE? Y N

\_\_\_\_\_  
ADDRESS CITY, STATE, ZIP PRIOR STUDIES/DATE/LOCATION

**\*MANDATORY TO SCHEDULE: LIST OF CURRENT MEDICATIONS, PERTINENT H & P, LABS, AND INSURANCE CARD\***

\_\_\_\_\_  
PATIENT APPT. DATE TIME OF APPT. SCHEDULED BY

\_\_\_\_\_  
ORDERING PHYSICIAN PRINT NAME ORDERING PHYSICIAN SIGNATURE CONTACT PERSON

\_\_\_\_\_  
ORDER DATE FAX TO SEND ALL REPORTS DIAGNOSIS/SYMPTOMS REQUIRING TEST - ICD10 *(indicate medical necessity and any clinical information clarifying each service being requested)*

DIAGNOSTIC RADIOLOGY PROCEDURES			
CT SCAN	W	W/O	W & W/O
Head			
Chest			
Abdomen			
Pelvis			
Neck			
Screening Lung			
<b>CTA</b>			
Head			
Neck			
Chest			
Abdomen			
CTA Runoff (Legs)			
<b>PET</b>			
PET FDG: Skull-to-Thigh			
PET FDG: Whole Body			
PET Axumin			
PET Netspot/DetectNET (dotatate)			
PET PSMA			
<b>MRI</b>			
Head			
Neck			
Abdomen			
Pelvis (Rectal, Female, Prostate, Bone)			
Spine (C)(T)(L)			
<b>MRA</b>			
Head/Neck (Order Both)			
<b>ULTRASOUND</b>			
Chest			
Abdomen			
Pelvis			
Legs			
Neck			
Thyroid			
Vascular Area			
Location:			
<b>Other:</b>			

INTERVENTIONAL RADIOLOGY PROCEDURES	
<b>BIOPSIES</b>	
Liver	
Lung	
Pancreas	
Abdominal/Pelvic	
Bone	
Thyroid	
Renal	
Node/Mass	
<b>PATH TEST NEEDED</b>	
Histopath/SurgPath	
Molecular (Caris)(Foundation One)	
Flow Cytometry	
<b>DRAINAGES</b>	
Thoracentesis	
Paracentesis	
Ureteral Stent	
Biliary	
Gastrostomy	
Nephrostomy	
<b>ANGIO/VENOGRAPHY</b>	
Diagnostic/Local Region	
<b>LINES</b>	
PICC/Hickman	
PAC	
SVC Stent	
ICV Filter/Removal	
<b>VASCULAR INTERVENTION</b>	
Chemo/Embolization	
Fibroid Embolization	
Radioembolization/ Y90	
<b>ABLATION LOCATION</b>	
Lung	
Liver	
Bone	
Kidney	
<b>OTHER</b>	