

Diagnostic Imaging Order Form

Patient Name:	Today's Date:
DOB:	Insurance Co.:
Phone:	Pre Auth Required: Y <input type="checkbox"/> N <input type="checkbox"/> Pre Auth #
Physician Phone Number:	Physician Fax Number:
Ordering Physician (Print):	Physician Signature:
Diagnosis: <input type="checkbox"/> Corresponding X-Rays as needed for MRI	

X-RAYS				
CHEST <input type="checkbox"/> CHEST 1V <input type="checkbox"/> CHEST 2V <input type="checkbox"/> STERNUM <input type="checkbox"/> RIBS <input type="checkbox"/> RT <input type="checkbox"/> LT ABDOMEN <input type="checkbox"/> KUB <input type="checkbox"/> ABDOMEN 2V	HEAD & NECK <input type="checkbox"/> SKULL <input type="checkbox"/> SINUS <input type="checkbox"/> NASAL <input type="checkbox"/> FACIAL <input type="checkbox"/> MANDIBLE <input type="checkbox"/> ST NECK	SPINE <input type="checkbox"/> C-SPINE 2-3V <input type="checkbox"/> C-SPINE ≥4V <input type="checkbox"/> T-SPINE 2V <input type="checkbox"/> THORACOLUMBAR 2V <input type="checkbox"/> L-SPINE 2-3V <input type="checkbox"/> L-SPINE FLEX/EXT <input type="checkbox"/> L-SPINE ≥5V <input type="checkbox"/> SACRUM/COCCYX SKELETAL SURVEY <input type="checkbox"/> BONE AGE	UPPER EXTREMITIES <input type="checkbox"/> R <input type="checkbox"/> L SHOULDER <input type="checkbox"/> R <input type="checkbox"/> L CLAVICAL <input type="checkbox"/> R <input type="checkbox"/> L AC JOINTS <input type="checkbox"/> R <input type="checkbox"/> L SCAPULA <input type="checkbox"/> R <input type="checkbox"/> L HUMERUS <input type="checkbox"/> R <input type="checkbox"/> L ELBOW <input type="checkbox"/> R <input type="checkbox"/> L FOREARM <input type="checkbox"/> R <input type="checkbox"/> L WRIST <input type="checkbox"/> R <input type="checkbox"/> L HAND <input type="checkbox"/> R <input type="checkbox"/> L FINGER _____ DIGIT	LOWER EXTREMITIES <input type="checkbox"/> PELVIS <input type="checkbox"/> SI JOINTS <input type="checkbox"/> R <input type="checkbox"/> L HIP <input type="checkbox"/> R <input type="checkbox"/> L FEMUR <input type="checkbox"/> R <input type="checkbox"/> L KNEE <input type="checkbox"/> R <input type="checkbox"/> L TIB/FIB <input type="checkbox"/> R <input type="checkbox"/> L ANKLE <input type="checkbox"/> R <input type="checkbox"/> L FOOT <input type="checkbox"/> R <input type="checkbox"/> L CALCANEUS <input type="checkbox"/> R <input type="checkbox"/> L TOE _____ DIGIT

ULTRASOUND	MAMMO	DEXA/ BONE DENSITY
GENERAL <input type="checkbox"/> TRUNK <input type="checkbox"/> ABDOMEN <input type="checkbox"/> GALLBLADDER <input type="checkbox"/> LIVER <input type="checkbox"/> RENAL <input type="checkbox"/> BLADDER <input type="checkbox"/> PELVIC <input type="checkbox"/> THYROID <input type="checkbox"/> TESTICULAR <input type="checkbox"/> BREAST <input type="checkbox"/> LT <input type="checkbox"/> RT <input type="checkbox"/> LIMITED <input type="checkbox"/> COMPLETE	<input type="checkbox"/> SCREENING <input type="checkbox"/> LT <input type="checkbox"/> RT <input type="checkbox"/> BILAT <input type="checkbox"/> DIAGNOSTIC <input type="checkbox"/> LT <input type="checkbox"/> RT <input type="checkbox"/> BILAT	<input type="checkbox"/> AXIAL SKELETON <input type="checkbox"/> AXIAL APPENDICULAR OTHER EXAMS REQUESTED: _____ _____ _____

	CT EXAM	CPT		CPT	MRI EXAM	CPT	
<input checked="" type="checkbox"/>	ABDOMEN & PELVIS W/	74177	<input type="checkbox"/>	SOFT TISSUE NECK W/O & W/	<input type="checkbox"/>	ELBOW W/O <input type="checkbox"/> LT <input type="checkbox"/> RT	
<input type="checkbox"/>	ABDOMEN & PELVIS W/ (ENTEROGRAPHY)	74177	<input type="checkbox"/>	SOFT TISSUE NECK W/O	<input type="checkbox"/>	FEMUR W/O & W/ <input type="checkbox"/> LT <input type="checkbox"/> RT	
<input type="checkbox"/>	ABDOMEN & PELVIS W/O & W/	74178	<input type="checkbox"/>	TEMPORAL BONE W/	<input type="checkbox"/>	FEMUR W/O <input type="checkbox"/> LT <input type="checkbox"/> RT	
<input type="checkbox"/>	ABDOMEN & PELVIS W/O & W/ (UROGRAPHY)	74178	<input type="checkbox"/>	TEMPORAL BONE W/O & W/	<input type="checkbox"/>	FOOT W/O & W/ <input type="checkbox"/> LT <input type="checkbox"/> RT	
<input type="checkbox"/>	ABDOMEN & PELVIS W/O	74170	<input type="checkbox"/>	TEMPORAL BONE W/O	<input type="checkbox"/>	FOOT W/O <input type="checkbox"/> LT <input type="checkbox"/> RT	
<input type="checkbox"/>	ABDOMEN & PELVIS W/O (KIDNEY STONE)	74170	<input type="checkbox"/>	T-SPINE W/	<input type="checkbox"/>	FOREARM W/O & W/ <input type="checkbox"/> LT <input type="checkbox"/> RT	
<input type="checkbox"/>	ABDOMEN W/	74160	<input type="checkbox"/>	T-SPINE W/O & W/	<input type="checkbox"/>	FOREARM W/O <input type="checkbox"/> LT <input type="checkbox"/> RT	
<input type="checkbox"/>	ABDOMEN W/O & W/ (RENAL MASS)	74170	<input type="checkbox"/>	T-SPINE W/O	<input type="checkbox"/>	HAND W/O & W/ <input type="checkbox"/> LT <input type="checkbox"/> RT	
<input type="checkbox"/>	ABDOMEN W/ (LIVER PROTOCOL)	74160	<input type="checkbox"/>	UPPER EXTREMITY W/ <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	HAND W/O <input type="checkbox"/> LT <input type="checkbox"/> RT	
<input type="checkbox"/>	ABDOMEN W/ (PANCREAS PROTOCOL)	74160	<input type="checkbox"/>	UPPER EXTREMITY W/O & W/ <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	HIP W/O & W/ <input type="checkbox"/> LT <input type="checkbox"/> RT	
<input type="checkbox"/>	ABDOMEN W/O	74150	<input type="checkbox"/>	UPPER EXTREMITY W/O <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	HIP W/O <input type="checkbox"/> LT <input type="checkbox"/> RT	
<input type="checkbox"/>	C-SPINE W/	72126	CT ANGIOGRAPHY			<input type="checkbox"/>	HUMERUS W/O & W/ <input type="checkbox"/> LT <input type="checkbox"/> RT
<input type="checkbox"/>	C-SPINE W/O & W/	72127	<input type="checkbox"/>	CTA ABDOMEN & PELVIS	<input type="checkbox"/>	HUMERUS W/O <input type="checkbox"/> LT <input type="checkbox"/> RT	
<input type="checkbox"/>	C-SPINE W/O	72125	<input type="checkbox"/>	CTA ABDOMEN	<input type="checkbox"/>	KNEE W/O & W/ <input type="checkbox"/> LT <input type="checkbox"/> RT	
<input type="checkbox"/>	CHEST W/	72160	<input type="checkbox"/>	CTA ABDOMINAL AORTA & LE RUNOFF	<input type="checkbox"/>	KNEE W/O <input type="checkbox"/> LT <input type="checkbox"/> RT	
<input type="checkbox"/>	CHEST W/O & W/	72170	<input type="checkbox"/>	CTA CHEST (PE PROTOCOL)	<input type="checkbox"/>	L-SPINE W/O & W/	
<input type="checkbox"/>	CHEST W/O	72150	<input type="checkbox"/>	CTA CHEST (THORACIC AORTA)	<input type="checkbox"/>	L-SPINE W/O	
<input type="checkbox"/>	LOW DOSE FOR LUNG CANCER SCREENING	71271	<input type="checkbox"/>	CTA HEAD (CIRCLE OF WILLIS)	<input type="checkbox"/>	ORBITS W/O & W/	
<input type="checkbox"/>	HEAD W/O & W/	70470	<input type="checkbox"/>	CTA LOWER EXTREMITY <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	ORBITS W/O	
<input type="checkbox"/>	HEAD W/O	70450	<input type="checkbox"/>	CTA NECK (CAROTID)	<input type="checkbox"/>	PELVIS W/O & W/	
<input type="checkbox"/>	LOWER EXTREMITY W/ <input type="checkbox"/> LT <input type="checkbox"/> RT	73701	<input type="checkbox"/>	CTA UPPER EXTREMITY <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	PELVIS W/O & W/ (UTERUS PROTOCOL)	
<input type="checkbox"/>	LOWER EXTREMITY W/O & W/ <input type="checkbox"/> LT <input type="checkbox"/> RT	73702	<input checked="" type="checkbox"/>	MRI EXAM		<input type="checkbox"/>	PELVIS W/O & W/ (PROSTATE PROTOCOL)
<input type="checkbox"/>	LOWER EXTREMITY W/O <input type="checkbox"/> LT <input type="checkbox"/> RT	73700	<input type="checkbox"/>	ABDOMEN W/O & W/	<input type="checkbox"/>	PELVIS W/O & W/ (RECTAL CANCER STAGING)	
<input type="checkbox"/>	L-SPINE W/	72132	<input type="checkbox"/>	ABDOMEN W/O & W/ (RENAL PROTOCOL)	<input type="checkbox"/>	PELVIS W/O	
<input type="checkbox"/>	L-SPINE W/O & W/	72133	<input type="checkbox"/>	ABDOMEN W/O & W/ (MRCP PROTOCOL)	<input type="checkbox"/>	SHOULDER W/O & W/ <input type="checkbox"/> LT <input type="checkbox"/> RT	
<input type="checkbox"/>	L-SPINE W/O	72131	<input type="checkbox"/>	ABDOMEN W/O	<input type="checkbox"/>	SHOULDER W/O <input type="checkbox"/> LT <input type="checkbox"/> RT	
<input type="checkbox"/>	MAXILLOFACIAL W/	70487	<input type="checkbox"/>	ABDOMEN W/O (MRCP ONLY)	<input type="checkbox"/>	SOFT TISSUE NECK W/O & W/	
<input type="checkbox"/>	MAXILLOFACIAL W/O & W/	70488	<input type="checkbox"/>	ANKLE W/O & W/ <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	SOFT TISSUE NECK W/O	
<input type="checkbox"/>	MAXILLOFACIAL W/O	70486	<input type="checkbox"/>	ANKLE W/O <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	TMJ W/O	
<input type="checkbox"/>	ORBITS W/	70481	<input type="checkbox"/>	BRAIN W/O & W/	<input type="checkbox"/>	T-SPINE W/O & W/	
<input type="checkbox"/>	ORBITS W/O & W/	70482	<input type="checkbox"/>	BRAIN W/O & W/ (IAC PROTOCOL)	<input type="checkbox"/>	T-SPINE W/O	
<input type="checkbox"/>	ORBITS W/O	70480	<input type="checkbox"/>	BRAIN W/O & W/ (PITUITARY PROTOCOL)	<input type="checkbox"/>	TIB/FIB W/O & W/ <input type="checkbox"/> LT <input type="checkbox"/> RT	
<input type="checkbox"/>	PELVIS W/	72193	<input type="checkbox"/>	BRAIN W/O & W/ (MS PROTOCOL)	<input type="checkbox"/>	TIB/FIB W/O <input type="checkbox"/> LT <input type="checkbox"/> RT	
<input type="checkbox"/>	PELVIS W/O & W/	72194	<input type="checkbox"/>	BRAIN W/O	<input type="checkbox"/>	WRIST W/O & W/ <input type="checkbox"/> LT <input type="checkbox"/> RT	
<input type="checkbox"/>	PELVIS W/O	72192	<input type="checkbox"/>	C-SPINE W/O & W/	<input type="checkbox"/>	WRIST W/O <input type="checkbox"/> LT <input type="checkbox"/> RT	
<input type="checkbox"/>	SINUS W/	70487	<input type="checkbox"/>	C-SPINE W/O	<input type="checkbox"/>	MRI ANGIOGRAPHY	
<input type="checkbox"/>	SINUS W/O & W/	70488	<input type="checkbox"/>	CHEST W/O & W/	<input type="checkbox"/>	MRA ABDOMEN	74185
<input type="checkbox"/>	SINUS W/O	70486	<input type="checkbox"/>	CHEST W/O	<input type="checkbox"/>	MRA HEAD W/O <input type="checkbox"/> MRV	70544
<input type="checkbox"/>	SOFT TISSUE NECK W/	70491	<input type="checkbox"/>	ELBOW W/O & W/ <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	MRA NECK W/O & W/	70549