

**This form is part of the patient's medical record and must be completed for referral**

Date of Referral \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Referring Provider Name \_\_\_\_\_

Patient Name (first, MI, last) \_\_\_\_\_

Patient Phone # (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (home) (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (work or cell)

D.O.B. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Written Diagnosis/Reason/Symptom for Exam(s) REQUIRED**

Medicare and other insurers require coding of specific/definitive diagnosis(es), sign(s) or symptom(s) to reflect the "medical necessity" for each test. **Rule out, Possible or Probable Conditions cannot be coded.** For Medicare Policy information see the Part B Bulletin or [www.noridian.com/medweb](http://www.noridian.com/medweb)

**Notes:** Height \_\_\_\_\_ Weight \_\_\_\_\_ Allergies \_\_\_\_\_  
 BUN/Creatinine \_\_\_\_ / \_\_\_\_ (date drawn) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**PRIOR EXAMS:**

\_\_\_\_\_ Date of Service \_\_\_\_\_ Facility Location \_\_\_\_\_

**LABS REQUIRED FOR IV CONTRAST STUDIES**

**Common Exams**

**X-ray** **No appointment required.**  
Specify additional views:

- Chest \_\_\_\_\_
- Sinuses \_\_\_\_\_
- Cervical Spine \_\_\_\_\_
- Thoracic Spine \_\_\_\_\_
- Lumbar Spine \_\_\_\_\_
- Scoliosis \_\_\_\_\_
- Abdomen Series \_\_\_\_\_
- KUB \_\_\_\_\_
- Pelvis only \_\_\_\_\_

- |    |    |       |                          |                                      |
|----|----|-------|--------------------------|--------------------------------------|
| It | rt |       | <input type="checkbox"/> | Pelvis w/ Lateral Hip                |
| It | rt | bilat | <input type="checkbox"/> | Hips                                 |
| It | rt | bilat | <input type="checkbox"/> | Ribs                                 |
| It | rt | bilat | <input type="checkbox"/> | Shoulder                             |
| It | rt | bilat | <input type="checkbox"/> | Elbow                                |
| It | rt | bilat | <input type="checkbox"/> | Wrist                                |
| It | rt | bilat | <input type="checkbox"/> | Hand                                 |
| It | rt | bilat | <input type="checkbox"/> | Finger                               |
| It | rt | bilat | <input type="checkbox"/> | Knee                                 |
| It | rt | bilat | <input type="checkbox"/> | Ankle                                |
| It | rt | bilat | <input type="checkbox"/> | Foot or <input type="checkbox"/> Toe |
| It | rt | bilat | <input type="checkbox"/> | Other _____ view(s)                  |

**Fluoroscopy**

- Esophagram (Barium Swallow)
- Upper GI
- Small Bowel
- Barium Enema  with air contrast
- IVP  VCUG
- Arthrogram joint \_\_\_\_\_
- Other (Specify)** \_\_\_\_\_

**Bone Densitometry (DEXA)**

- Spine & Femur
- Other (Specify)** \_\_\_\_\_

**Breast Imaging to move from this form to a new Breast Health form by January 2010**

**Mammography**

- Screening (no symptoms)
- It rt bilat  Diagnostic (ultrasound if needed &/or recommended follow up)
- It rt bilat  Needle Loc
- It rt bilat  Stereotactic Breast Biopsy
- It rt bilat  Galactogram

**Ultrasound**

- It rt bilat  Breast
- It rt bilat  Breast Cyst Aspiration
- It rt bilat  Guided Breast Biopsy
- Vascular: (Specify) \_\_\_\_\_
- AAA Screen (Medicare only)
- Cardiac Echo
- Abdomen (Complete)
- Abdomen (Limited) Specify: \_\_\_\_\_
- Renal
- Pelvic (transabdominal &/or transvaginal as needed for diagnostic visualization)
- Pelvic transvaginal only / Doppler
- OB LMP: \_\_\_\_ / \_\_\_\_  
 \_\_ Multiple \_\_ High Risk \_\_ Follow-up
- Biophysical Profile
- Thyroid
- Testicular / Doppler
- Other (Specify)** \_\_\_\_\_

**Appointments:**

Exam \_\_\_\_\_  
 M T W Th F S Sn  
 Date \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Time \_\_\_\_\_ : \_\_\_\_\_

Exam \_\_\_\_\_  
 M T W Th F S Sn  
 Date \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Time \_\_\_\_\_ : \_\_\_\_\_

- Call patient to schedule
- Patient will call to schedule
- Return patient to the office with films
- Call STAT (\_\_\_\_)\_\_\_\_-\_\_\_\_\_
- Fax STAT (\_\_\_\_)\_\_\_\_-\_\_\_\_\_
- Fax Routine (\_\_\_\_)\_\_\_\_-\_\_\_\_\_

Send:  CD ROM  Films

**Additional reports to:** \_\_\_\_\_

**Follow-Up Appointment:**

Date \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Time \_\_\_\_\_ : \_\_\_\_\_

**PCP:** \_\_\_\_\_

**Name of insurance is required:** \_\_\_\_\_

**Insurance authorization #**  
 (if needed): \_\_\_\_\_

**Referring Provider Signature**  
 (Required for Exam) →

For Office Use Only

Diagnostic Imaging Phys Orders



**Radiology Order Form**

**THIS REFERRAL IS CONFIDENTIAL AND IS INTENDED SOLELY FOR THE USE OF THE MEDICAL PROVIDER NAMED ABOVE. IF YOU ARE NOT THE INTENDED RECIPIENT OR THE INTENDED RECIPIENT'S AGENT, AND HAVE RECEIVED THIS COMMUNICATION IN ERROR, NOTIFY SENDER IMMEDIATELY AND DESTROY THIS DOCUMENT.**