**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

**Notes:** Height__________ Weight__________ Allergies______________________

BUN/Creatinine _____ / _____ (date drawn) _____ / _____ / _____ ☐ YES Hydration at Radiologist's discretion

***LABS REQUIRED FOR IV CONTRAST STUDIES***

**PRIOR EXAMS:**

______________ Date of Service ______________ Facility Location

## Specialty Exams

### Nuclear Medicine

☐ Lung Scan
☐ Biliary (HIDA)
☐ Renal Scan
☐ Cardiac Blood Pool (MUGA)
☐ Myocardial Stress Test and Rest
☐ Treadmill ☐ Adenosine
☐ Gastric Emptying Study (GES)

Bone Scan:
☐ Multiple ☐ 3-Phase ☐ SPECT
(area of concern ______________________)
☐ Whole Body

Thyroid: ☐ Uptake & Scan
☐ Scan Only

☐ Venogram
☐ **Other** (specify) ______________________

### CT Scan

**(contrast & 3D reconstruction as clinically indicated by radiologist); or __no contrast**

☐ Head ☐ Sinuses
☐ Neck ☐ Ltd. Sinus
☐ C-spine ☐ LandmarX
☐ T-spine
☐ L-spine

☐ CT KUB
☐ Chest
☐ Abdomen
☐ Abdomen & Pelvis
☐ CT Enterography
☐ Pelvis
☐ **Other** (specify)________

☐ CTA Head & Neck
☐ CTA Chest
☐ CTA Coronary
☐ CTA Abdomen
☐ CTA Abdomen & Pelvis
☐ CTA Pelvis
☐ **CTA** Other (specify) ________

### MRI Exam

**(contrast & 3D reconstruction as clinically indicated by radiologist); or ___no contrast**

☐ Head________________
☐ Thyroid/larynx
☐ C-spine
☐ T-spine
☐ L-spine
☐ Breast lt rt bilat
☐ Cardiac
☐ Soft tissue (specify) _________

**Extremity**

☐ w / joint arthrogram
lt rt ☐ Hand
lt rt ☐ Wrist
lt rt ☐ Elbow
lt rt ☐ Shoulder
lt rt ☐ Hip
lt rt ☐ Knee
lt rt ☐ Ankle
lt rt ☐ Foot lt rt ☐ **Other** (specify) ________

**Pacemaker: Y / N**

☐ Abdomen
☐ MRCP
☐ MRA (specify)
______________________

### Injections & Procedures

☐ Diagnostic & Therapeutic Injection (specify) ______________________
☐ Interventional Procedure (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.**