Referred By Physician_____ Signature_____

Tel_____ Fax_____ ☐ Stat Call Report ☐ Fax Report ☐ CD w Patient

RULE OUT IS NOT A PRIMARY DIAGNOSIS **BOLD TESTS** = Medicare Policy

Symptoms _____

Patient Information Last_____ First_____ Tel_____

SS #_____ DOB_____

Authorization Necessary? ☐ Yes ☐ No

Authorization # _____

Date of Request _____

Appointment Date_____ **Time**_____ ☐ **am** ☐ **pm**

☒ **Creatinine and GFR will be performed if needed for patients requiring IV contrast**

Diagnostic

- ☐ Abdomen KUB
- ☐ Abdomen 2 Views
- ☐ Abdomen Series
- ☐ Ankle ☐ L ☐ R
- ☐ Barium Enema
- ☐ Barium Enema w Air
- ☐ **Barium SWL Esph**
- ☐ **Mod Barium SWL Video - sp. Therp.**
- ☐ Clavicle ☐L ☐R
- ☐ Chest PA & LAT
- ☐ Ribs Bilat.
- ☐ Ribs Unilat.☐L ☐ R
- ☐ **DEXA Freq**
- ☐ Elbow ☐L ☐R
- ☐ Eyes for F/B
- ☐ Femur ☐L ☐R
- ☐ Fingers ☐L ☐R
  Digit: _____
- ☐ Foot ☐L ☐R
- ☐ Forearm ☐L ☐R
- ☐ GI Series
- ☐ Hand ☐L ☐R
- ☐ Hip Bilateral
- ☐ Hip Uni ☐L ☐R
- ☐ Humerus ☐L ☐R
- ☐ Knee ☐L ☐R
- ☐ Neck Soft Tissue
- ☐ Pelvis 1V
- ☐ Small Bowel Series

Diagnostic

- ☐ Shoulder ☐ L ☐ R
- ☐ Tibia/Fibula ☐ L ☐ R
- ☐ Wrist ☐ L ☐ R
- ☐ Scoliosis Study
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine

MRI/MRA

- ☐ **Contrast if Indicated**
- ☐ MRI Abdomen
- ☐ **MRI Brain** ☐ MRCP
- ☐ MRI Breast
- ☐ MRI Chest
- ☐ MRI Pelvis
- ☐ MRI LW Ext ☐L ☐R
- ☐ MRI UP Ext ☐L ☐R

All UP/LW Ext Specify Area: _____

- ☐ **MRI Cervical Spine**
- ☐ **MRI Thoracic Spine**
- ☐ **MRI Lumbar Spine**

MRA

- ☐ **Contrast if Indicated**
- ☐ **MRA Abdomen**
- ☐ **MRA Chest**
- ☐ **MRA Neck**
- ☐ **MRA Pelvis**
- ☐ **MRA/MRV Head**
- ☐ **MRA LW Ext** ☐L ☐R

All UP/LW Ext Specify Area: _____

CT Scans

- ☐ **Contrast if Indicated**
- ☐ **Abdomen**
- ☐ **Pelvis**
- ☐ **Brain**
- ☐ **Chest**
- ☐ LW EXT ☐L ☐R
- ☐ UP EXT ☐L ☐R
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine
- ☐ BxPerc Needle

Specify Area: _____

CTA

CTAs require Contrast

- ☐ CTA Abdomen
- ☐ CTA Aorta
- ☐ CTA Chest
- ☐ CTA Pelvis

Special Procedures

- ☐ Discogram Crv/Thor
- ☐ Discogram Lumbar
- ☐ Myelogram Lumbar
- ☐ Myelogram Cervical
- ☐ Myelogram Pan
- ☐ Arthrogram

Specify Joint: _____

Nuclear Medicine

- ☐ **Bone Scan**
- ☐ **Bone Scan 3 Phase**
- ☐ **Bone Spect**
- ☐ Add. X-Rays if Bone Scan Positive
- ☐ GI Bleed
- ☐ HIDA w/ Pharm
- ☐ Inflam. Process WB
- ☐ Kidney Scn Sgl wo Pharm
- ☐ Kidney Scn w/wo Pharm
- ☐ Lymphoscint.
- ☐ Muga Sgl.
- ☐ Lung Scan
- ☐ Tumor Local.
- ☐ **Myocard Mult R/S**
- ☐ **Myocard Sgl**

Ultrasound

- ☐ Abdominal
- ☐ Pelvis if indicated
- ☐ ABI
- ☐ **Carotid**
- ☐ OB
- ☐ Paracentesis/ Thoracentesis
- ☐ Pelvic
- ☐ TransV if indicated
- ☐ Retroperitioneal
- ☐ Scrotum
- ☐ **Thyroid**
- ☐ USG Biopsy

Specify Area: _____

- ☐ **Venous Ext UP** ☐L ☐R
- ☐ **Venous Ext LW** ☐L ☐R

Mammogram

- ☐ **Screening Mammo** (asymptomatic patients) with additional views and Ultrasound as determined by the Radiologists. 3D or 2D per patient's preference.
- ☐ Breast Ultrasound ☐ L ☐ R ☐ Bilateral
- ☐ **Diagnostic Mammography**
  3D or 2D and Ultrasound will be performed as determined by the Radiologist.
  ☐ L ☐ R ☐ Bilateral
- ☐ Stereotactic Biopsy
- ☐ Ultrasound Breast Biopsy ☐L ☐R ☐ Bilateral

_____

_____

AdventHealth Hendersonville

LMRP RADIOLOGY ORDERS

035-0119

FAX TO: 828-650-6920

PHYORDER

Patient ID