*****Please see page 2 for appropriate FAX number based on requested location*****

Patient Name: _____ DOB: _____ Pt. Weight _____lbs.
Patient Phone No: _____ Alternate Phone No: _____ SSN: XXX-XX-_____
☐ Please call patient to schedule exam Preferred Location Request: (See page 2 for list of locations) _____
☐ STAT (Please call to schedule) ☐ Called Report (Provider Cell/After Hours Number) _____
Signs/Symptoms_____
Clinical History: (Please be specific) _____
CPT Code(s): _____ ICD-10 Code(s) Required: _____
Insurance Name: _____ ID:_____ Group # _____
Preauthorization #: _____ Preauthorization NOT needed per_____
(Include Print Screen or Person's Name, Date, Phone #)
I authorize Creatinine and Urine HCG as needed / Per exam protocol. Current Creatinine value _____ Date drawn ___/___/___
Clinician Printed Name:_____ Clinician Signature: _____ Date: ___/___/___ Time: _____

DO NOT WRITE IN MARGIN

DO NOT WRITE IN MARGIN

X-RAY / Bone Density

☐ Chest ☐ 1 view ☐ 2 views
☐ Ribs ☐ Right ☐ Left
☐ Abdomen ☐ 2 views ☐ 3 views
☐ Pelvis
☐ Upper Extremity ☐ Right ☐ Left
Specify _____
☐ Lower Extremity ☐ Right ☐ Left
Specify _____
☐ Spine ☐ Cervical ☐ Thoracic ☐ Lumbar
☐ Other _____

Breast Imaging

☐ Digital Screening Mammogram
☐ Right ☐ Left ☐ Bilateral

☐ *I authorize additional breast imaging studies if medically indicated to include:*
- *Diagnostic Mammography-Left, Right or Bilateral*
- *Breast Ultrasound-Left, Right or Bilateral*
- *MRI Breast-Left, Right or Bilateral*
- *Stereotactic Biopsy-Left, Right or Bilateral*
- *CESM Enhanced Biopsy-Left, Right or Bilateral*
- *Ultrasound Biopsy-Left, Right or Bilateral*
- *MRI Breast Biopsy-Left, Right or Bilateral*

☐ Screening Breast Ultrasound (ABUS) if breast density is >50%
☐ Right ☐ Left ☐ Bilateral
☐ Diagnostic Mammogram
☐ Right ☐ Left ☐ Bilateral
☐ Diagnostic Breast Ultrasound
☐ Right ☐ Left ☐ Bilateral
☐ Contrast Enhanced Spectral Mammography/CESM
Creatinine Level ____Draw Date _____
☐ Right ☐ Left ☐ Bilateral
☐ Stereotactic Breast Biopsy
☐ Right ☐ Left ☐ Bilateral
☐ Ultrasound Guided Breast Biopsy
☐ Right ☐ Left ☐ Bilateral
☐ Breast MRI
☐ Right ☐ Left ☐ Bilateral
☐ Breast MRI Biopsy
☐ Right ☐ Left ☐ Bilateral
☐ Lymphoscintigraphy ☐ Needle Localization
☐ Right ☐ Left ☐ Bilateral
☐ Other _____

Fluoroscopy

☐ Barium Swallow
☐ Modify Barium Swallow - Speech Therapy
☐ Upper GI
☐ Small Bowel Series ☐ Barium Enema
☐ Small Bowel Enteroclysis
☐ VCUG
☐ Myelogram
☐ Cervical ☐ Thoracic ☐ Lumbar
☐ Other _____

MRI

☐ **With Contrast** ☐ **Without Contrast**
☐ **With and Without**
☐ Chest ☐ Abdomen
☐ MRCP with Abdomen ☐ Pelvis
☐ Brain ☐ MRA Brain (without contrast)
☐ Breast ☐ Cardiac
☐ Extremity ☐ Right ☐ Left
Specify _____
☐ MRA (Specify) _____
☐ Bony Pelvis ☐ Hip ☐ Right ☐ Left
☐ Spine ☐ Cervical ☐ Thoracic ☐ Lumbar
☐ Other _____

Nuclear

☐ Bone Scan
☐ Whole Body ☐ SPECT ☐ 3 Phase
☐ I - 123 Whole Body Scan ☐ Ceterec WBC
☐ HIDA Scan
☐ HIDA Scan with Ejection Fraction (EF).
☐ Gastric Emptying ☐ Lung (VQ) Scan
☐ Parathyroid ☐ Thyroid ☐ Thyroid Uptake
☐ Renogram ☐ Renogram with Lasix
☐ Rest MUGA ☐ Exercise Stress
☐ Lexiscan Stress
☐ Other: _____

Computed Tomography

☐ **With Contrast** ☐ **Without Contrast**
☐ **With and Without**
☐ Brain ☐ Sinuses ☐ Limited Sinuses
☐ Chest ☐ CTA Chest ☐ Cardiac CT
☐ CTA Cardiac (includes Ca+ scoring and CTA Chest)
☐ Lung Screening ☐ 3 months ☐ 6 months
☐ Abdomen ☐ Abdomen and Pelvis
☐ CT Renal Stone ☐ Urogram ☐ CT IVP
☐ Extremity ☐ Right ☐ Left
Specify _____
☐ Other _____

Ultrasound

☐ Aorta ☐ Carotid ☐ Thyroid
☐ Arterial _____ ☐ Venous _____
☐ Complete Abdomen ☐ Gallbladder/RUQ
☐ Renal ☐ Renal Artery
☐ Pelvis with Endovaginal and Doppler, if needed
☐ ABI
☐ Extremity Non-Vascular _____
☐ Scrotum ☐ Scrotum w/Doppler, if needed
☐ Paracentesis ☐ Thoracentesis
☐ Biopsy _____
☐ Other _____

OB Ultrasound

☐ OB Ultrasound 1st Trimester
with Endovaginal and Doppler, if needed

☐ OB Ultrasound 2nd/3rd Trimester
Specify _____

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MISSION HEALTH

Outpatient Imaging Order

		Bone Density	Breast Biopsy	Breast Imaging	CT	Fluoroscopy	MRI	Nuclear Medicine	Ultrasound	X-Ray
Angel Medical Center	124 One Center Ct., Franklin, NC 28734 844-919-3880 | Fax 877-569-6131	X	X	X	X	X	X	X	X	X
Blue Ridge Regional Hospital	125 Hospital Dr. Spruce Pine, NC 28777 844-902-3810 | Fax 877-572-8053	X	X	X	X	X	X	X	X	X
Highlands - Cashiers Hospital	190 Hospital Dr. Highlands, NC 28711 844-974-3782 | Fax 877-574-0526	X		X	X	X	X		X	X
Hope Women's Imaging Center	100 Ridgefield Ct. Ste. C, Asheville, NC 28806 844-519-0200 | Fax 877-563-8803	X	X	X	X				X	X
McDowell Hospital	430 Rankin Dr., Marion, NC 28752 844-974-3783 | Fax 877-568-6192	X	X	X	X	X	X	X	X	X
Mission Hospital	509 Biltmore Ave., Asheville, NC 28801 844-519-0200 | Fax 877-563-8803				X**	X**	X**	X	X**	X
Mission Children's Hospital	11 Vanderbilt Park Dr., Asheville, NC 28803 844-519-0200 | Fax 877-563-8803					X	X		X	X
Transylvania Regional Hospital	260 Hospital Dr., Brevard, NC 28712 844-974-0064 | Fax 877-572-1222	X	X	X	X	X	X	X	X	X
Mission Breast Centers										
Asheville (MBCA)	534 Biltmore Ave., Asheville, NC 28801 844-519-0200 | fax 877-563-8803		X	X					X	
Biltmore Park (MBCB)	2 Town Square Blvd. Suite 110, Asheville, NC 28803 844-519-0200 | fax 877-563-8803			X*						
Mission Imaging Services *(Independent Diagnostic Testing Facility)*										
Asheville (MISA)	534 Biltmore Ave., Asheville, NC 28801 844-519-0200 | fax 877-568-0767	X	X		X	X			X	X
Clyde (MISH)	360 Hospital Dr., Clyde, NC 28791 844-519-0200 | fax 877-568-0767	X		X*					X	X
MRI (MISM)	222 Asheland Ave., Asheville NC 28801 844-519-0200 | fax 877-568-0767						X			
Carolina Spine (MISV)	7 Vanderbilt Park Dr. Asheville, NC 28803 844-519-0200 | fax 877-568-0767						X		X	
Mission Pardee Health (MISP)	2695 Hendersonville Rd., Arden, NC 28704 844-519-0200 | fax 877-568-0767				X				X	X

*Screening mammography services (only) provided at these locations
** Mission Hospital can only be scheduled for non-ambulatory, pacemaker, SNF, severe contrast allergy, anesthesia or sedation

ADULT PATIENT PREPARATIONS FOR EXAMS

- **ABDOMINAL/GALLBLADDER ULTRASOUND**
  Nothing to eat or drink 6 hours before the exam
- **BARIUM ENEMA**
  Obtain 24-hour prep kit from your physician or purchase at your local pharmacy as directed by your physician and follow package instructions
- **CT OF THE ABDOMEN/PELVIS**
  Oral Contrast Enhanced CT
  Nothing to eat or drink 2 hours prior to exam.
  Patient should contact referring provider regarding withholding any diabetic medications
- **GI SERIES AND/OR SMALL BOWEL STUDY**
  Nothing to eat or drink after midnight before the exam
- **HIDA SCAN**
  Nothing to eat or drink 4 hours prior to exam
- **MRI OF THE ABDOMEN**
  Nothing to eat or drink 4 hours prior to the exam
- **INVASIVE PROCEDURES**
  Patient should contact referring provider regarding withholding blood thinners prior to scan
- **THYROID SCAN**
  Patient should contact referring provider regarding withholding thyroid medications prior to scan

Referring provider questions regarding withholding medication can be answered peer to peer by calling Rad Reach at 828-213-9500

REGISTRATION: Please plan to arrive 20 minutes early to register