

**OUTPATIENT ORDER – PRECERTIFIED EXAMS
IMAGING SERVICES**

PLACE LABEL HERE

Imaging Scheduling:

Phone: 678-312-3444

Fax: 678-442-9736

Precertification: 678-312-4095

GMC to Schedule Patient? Yes No

Patient already scheduled? Yes No

Appointment Date: _____

Arrival Time: _____

Exam Time: _____

GMC to Precert Patient? Yes No

If yes, copy of insurance card & clinical documentation must be sent with order

Medicare? Yes No

Precertification # : _____

NAME: _____

DOB: _____

Phone#1: _____

Phone#2: _____

Language: _____

PATIENT MUST BRING THIS ORDER ON THE DATE OF SERVICE.

Allergies: _____

Symptoms/Diagnosis (with ICD-9 codes): _____

EVALUATE CREATININE LEVEL PRIOR TO TEST UNLESS LEVEL PERFORMED WITHIN 7 DAYS. RESULT: _____

MRI	MRI/CT ANGIOGRAPHY	CT	NUCLEAR MEDICINE
<input type="checkbox"/> Contrast per Radiologist discretion <input type="checkbox"/> With Contrast <input type="checkbox"/> Without Contrast <input type="checkbox"/> With and Without Contrast	<input type="checkbox"/> With Contrast <input type="checkbox"/> Without Contrast <input type="checkbox"/> With and Without Contrast	<input type="checkbox"/> Contrast per Radiologist discretion <input type="checkbox"/> With Contrast <input type="checkbox"/> Without Contrast <input type="checkbox"/> With and Without Contrast	

Prefer Open High Field MRI
 Orbits for MRI clearance

Neuro:

- Brain
- Neck (soft tissue)
- Pituitary
- IAC

Spine:

- Cervical Lumbar
- Thoracic Sacrum-SI Joints

Abdominal:

- Abdomen MRCP
- Adrenals Kidney
- Liver
- Pelvis (Gyn-Prostate)

Musculoskeletal:

- Rt Lt Bilateral
- Shoulder Hip
- Elbow Knee
- Wrist Ankle
- Pelvis (Bony)/Hip
- Foot
- Bone: _____

Arthrogram (with contrast)
Site: _____

Breast:

- Rt Lt Bilateral
- 3D Reconstruction

MRI Angiography

- Circle of Willis (Intracranial)
- Carotid Bifurcations
- Abdomen (Aorta, Renals, Mesenteric)
- Pelvis
- Run-off (Aorta and Bilateral legs)
- MR Venography - Brain
- Other: _____

CT Angiography

- Brain (Aneurysm)
- Head/Neck (Stenosis/TIA)
- Chest Pulmonary Aortic
- Abdomen AND Pelvis (Renals OR Mesenteric)
- Pelvis
- Run-off (Aorta and Bilateral legs)
- Other: _____

OTHER

Neuro:

- Head
- Neck (soft tissue)
- Sinus
- Temporal Bone

Spine:

- Cervical
- Thoracic
- Specify Levels _____
- Lumbar
- Post Myelogram

Body Imaging:

- Chest
- Abdomen AND Pelvis
- Abdomen Only
- Pelvis Only
- Renal Stone Panel** (Abdomen & Pelvis w/o contrast)
- Enterography (Volumen) (Abdomen & Pelvis w contrast)

Musculoskeletal:

- Upper Extremity w/ 3D Recons
- Lower Extremity w/ 3D Recons
- Rt Lt
- Site: _____

Arthrogram (with contrast)
Site _____

Biopsy: (CT guided)
Specify: _____

Bone Scan:

- (with correlating films if medically necessary)
 - Whole Body
 - Limited
- Gastric Emptying
- Hepatobiliary (HIDA)
 - With Pharmacological Intervention for EF
- WBC Scan (Gallium/Ceretec)
- Lung Scan (V/Q)
- Renal with Lasix (furosemide)
- Renal with Vasotec (enalapril)
- Thyroid Uptake & Scan
- Other: _____

SPECT/CT

- Bone Scan
 - Whole Body OR Limited
- Brain
- Parathyroid
- Octreoscan
- Proscint (chest/abd/pelvis)
- Renal
- Other: _____

PET/CT

- Brain (Dementia, Alzheimer's)
- Cancer (Skull base to mid-thigh)
- WB Melanoma

STAT Results to: Phone or Fax: _____

Hold Patient and Call Physician's cell #: _____

Date Time Physician Signature Physician Name (print) PID Number

Tests should only be ordered that are medically necessary for the diagnosis, symptoms, and/or treatment. The patient may be billed for tests that are not deemed necessary by payors. Please submit all (appropriate) clinical indications for all test(s) ordered. The procedure will **not** be performed in the absence of the completed form including the appropriate diagnosis and/or ICD-9 code supporting the ordered procedure. Ordering physicians are responsible for the accuracy of the information provided.

