

# OUTPATIENT ORDER IMAGING SERVICES

**Imaging Scheduling:**

 Phone: 678-312-3444  
 Fax: 678-442-9736  
 Precertification: 678-312-4095

**GHS to Schedule Patient?**  Yes  No  
 Patient already scheduled?  Yes  No  
 Appointment Date: \_\_\_\_\_

**Name:** \_\_\_\_\_

**Location of Scheduled Appointment:**

- 
- Gwinnett Medical Center – Lawrenceville
- 
- 
- Gwinnett Women's Pavilion
- 
- 
- 575 Outpatient Imaging Center
- 
- 
- Gwinnett Medical Center – Duluth
- 
- 
- Outpatient Center at GMC – Duluth
- 
- 
- GMC Imaging Center – Hamilton Mill

Arrival Time: \_\_\_\_\_

Exam Time: \_\_\_\_\_

 Medicare?  Yes  No

**GMC to Precert Patient?**  Yes  No

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

Precertification # : \_\_\_\_\_

**DOB:** \_\_\_\_\_

Phone#1: \_\_\_\_\_

Phone#2: \_\_\_\_\_

Language: \_\_\_\_\_

**PATIENT MUST BRING THIS ORDER ON THE DATE OF SERVICE.**
**Allergies:** \_\_\_\_\_

**ALL FLUOROSCOPY & ULTRASOUND PROCEDURES MUST BE SCHEDULED.**
**Symptoms/Diagnosis (with ICD-9 codes):** \_\_\_\_\_

**IMAGING WILL EVALUATE CREATININE LEVEL PRIOR TO CONTRASTED TESTS UNLESS LAST LEVEL PERFORMED WITHIN 7DAYS.  
DATE / RESULT:** \_\_\_\_\_

SKULL & FACE	CHEST	ABDOMEN & GI TRACT	ULTRASOUND
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- 
- Skull Series
- 
- 
- Facial Bones
- 
- 
- Orbits:
- 
- 
- Rt
- 
- Lt
- 
- 
- Nasal Bones
- 
- 
- Sinus Series:
- 
- 
- Full Series
- 
- Limited
- 
- 
- Other: \_\_\_\_\_

- 
- Chest:
- 
- 
- PA & Lateral
- 
- 
- Decubitus:
- 
- 
- Rt
- 
- Lt
- 
- Bilateral
- 
- 
- Ribs:
- 
- 
- Rt
- 
- Lt
- 
- Bilateral
- 
- 
- Sternum
- 
- 
- Other: \_\_\_\_\_

- 
- Acute Abdominal Series
- 
- 
- Barium Enema:
- 
- 
- Single
- 
- Air Contrast
- 
- 
- Barium Swallow (esophagus)
- 
- 
- KUB
- 
- 
- Small Bowel Series
- 
- 
- Upper GI Series
- 
- 
- Other: \_\_\_\_\_

- 
- Abdomen Complete
- 
- 
- Abdomen Limited
- 
- Specify site : \_\_\_\_\_
- 
- 
- Aorta
- 
- 
- Kidneys
- 
- 
- Paracentesis:
- 
- 
- OB Pelvis
- 
- OB Transvaginal
- 
- EDD \_\_\_\_\_ LMP \_\_\_\_\_
- 
- 
- Pelvic Non-OB (transvaginal & transabdominal)
- 
- 
- Transvaginal ONLY
- 
- 
- Transabdominal ONLY
- 
- 
- Retroperitoneum (AA, IVC)
- 
- 
- Sonohysterogram
- 
- 
- Testicular
- 
- 
- Thoracentesis:
- 
- 
- Rt
- 
- Lt
- 
- 
- Thyroid
- 
- 
- Thyroid Biopsy:
- 
- 
- Rt
- 
- Lt
- 
- Bilateral
- 
- 
- Venous Upper Extremity:
- 
- 
- Rt
- 
- Lt
- 
- Bilateral
- 
- 
- Venous Lower Extremity:
- 
- 
- Rt
- 
- Lt
- 
- Bilateral
- 
- 
- Other: \_\_\_\_\_

SPINE & PELVIS	EXTREMITIES	OTHER PROCEDURES
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- 
- Cervical Spine
- 
- 
- Thoracic Spine
- 
- 
- Lumbar Spine
- 
- 
- Pelvis
- 
- 
- Sacroiliac Joint
- 
- 
- Hip:
- 
- 
- Rt
- 
- Lt
- 
- Bilateral
- 
- 
- Sacrum and/or Coccyx specify: \_\_\_\_\_
- 
- 
- Scoliosis Series
- 
- 
- Other: \_\_\_\_\_

- 
- Rt
- 
- Lt
- 
- Bilateral
- 
- 
- Specify site: \_\_\_\_\_
- 
- 
- Bone Length Scanogram
- 
- 
- Standing / Weight-Bearing
- 
- 
- Bone Age
- 
- 
- Other: \_\_\_\_\_

<b>GU TRACT</b>
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- 
- Cystogram:
- 
- 
- Static
- 
- Voiding
- 
- 
- IV Pyelogram with Post Void
- 
- 
- Other: \_\_\_\_\_

- 
- Arthrogram: (with Contrast)
- 
- Specify: \_\_\_\_\_
- 
- 
- Rt
- 
- Lt
- 
- 
- with MRI
- 
- 
- with CT
- 
- 
- Hip Injection:
- 
- 
- Rt
- 
- Lt
- 
- 
- Hysterosalpingogram
- 
- 
- Myelogram with CT to follow:
- 
- 
- Cervical
- 
- 
- Thoracic
- 
- Specify level: \_\_\_\_\_
- 
- 
- Lumbar
- 
- 
- Other: \_\_\_\_\_

**Physician Name (print):** \_\_\_\_\_  STAT Results to:  Phone  Fax: \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_  Hold patient and Call Physician's cell: \_\_\_\_\_

**Physician NPI#:** \_\_\_\_\_ **Date:** \_\_\_\_\_  CC report to: \_\_\_\_\_

**\* 2 - 18692 \***

# OUTPATIENT ORDER IMAGING SERVICES

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 codes supporting the ordered procedure. Ordering physicians are responsible for the accuracy of the information provided.

## OB Ultrasound

Premature Separation of Placenta	641.23
Unspecified Malpresentation	652.93
Placenta Previa without Hemorrhage	641.03
Placenta Previa with Hemorrhage	641.13
Normal First Pregnancy Supervision	V22.0
Other Normal Pregnancy Supervision	V22.1
Insufficient Prenatal Care	V23.7
Twin Pregnancy	651.03
Triplet Pregnancy	651.13
Unspecified Multiple Gestations	651.93
Premature labor	
(After 22 wks but before 37 wks)	644.03
Premature labor	
(After 37 wks)	644.13

## Amniotic Fluid Index:

▪ Premature Rupture of Membranes (PROM)	658.12
▪ Polyhydramnios	657.03
▪ Oligohydramnios	658.03

## Estimated Fetal Weight:

▪ Excessive Fetal Growth (large for dates)	656.63
▪ Poor Fetal Growth (small for dates)	656.53
▪ Uterine Size Date Discrepancy	649.63

## Biophysical Profile:

▪ Decreased Fetal Movement	655.73
▪ Fetal Distress	656.33
▪ Post Term Pregnancy (over 40 – 42 wks)	645.13
▪ Prolonged Pregnancy (beyond 42 wks)	645.23

## Cervical Length:

▪ Cervical Incompetence	654.53
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