

ORTHOPEDIC OUTPATIENT ORDER 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: _____

Location of Scheduled Appointment:
 Gwinnett Medical Center – Lawrenceville
 575 Outpatient Imaging Center
 Gwinnett Medical Center – Duluth
 Outpatient Center at GMC – Duluth
 GMC Imaging Center – Hamilton Mill

PATIENT MUST BRING THIS ORDER ON THE DATE OF SERVICE.

Allergies: _____

ALL INTERVENTIONAL RADIOLOGY EXAMS MUST BE SCHEDULED.

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

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

MRI	CT	DIAGNOSTIC X RAY	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"/> 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:
 Head
 Neck (soft tissue)
 Sinus
 Temporal Bone

CHEST
 PA & Lateral Chest
 PA only
 Decubitus
 RT LT Bilateral
 Ribs
 RT LT Bilateral
 Sternum

Bone Scan:
(with correlating films if medically necessary)
 Whole Body
 Limited

Spine:
 Cervical Lumbar
 Thoracic Sacrum-SI Joints

Spine:
 Cervical
 Thoracic
Specify Levels _____
 Lumbar
 Post Myelogram

SPINE & PELVIS
 Cervical
 Thoracic
 Lumbar
 Sacroiliac Joints
 Brain (Aneurysm)
 Hips
 RT LT Bilateral
 Sacrum and/or Coccyx
 Pelvis
 Scoliosis Series

SPECT/CT

Bone Scan
 Whole Body OR Limited

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

Body Imaging:
 Chest
 Abdomen AND Pelvis
 Abdomen Only
 Pelvis Only

EXTREMITIES
 Specify site: _____
 RT LT Bilateral

ULTRASOUND

Venous
 Upper Extremity
 Lower Extremity
 RT LT Bilateral

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

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

Scanogram for leg length
 Standing/Weight-Bearing
 Bone Age

INTERVENTIONAL

Consultation for:
 Kyphoplasty
 Vertebroplasty
 Other: _____

Arthrogram (with contrast)
Site _____

Arthrogram (with contrast)
Site _____

BONE DENSITOMETRY

Biopsy: (CT guided)
Specify: _____

Physician Name (print): _____
Physician Signature: _____
Physician NPI#: _____ Date: _____

STAT Results to : Phone Fax: _____
 Hold patient and Call Physician's cell: _____
 CC report to: _____

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.

