

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

**PATIENT MUST BRING THIS ORDER ON THE DATE OF SERVICE.**
**ALL INTERVENTIONAL RADIOLOGY EXAMS MUST BE SCHEDULED.**
**Allergies:** \_\_\_\_\_

**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

**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 \_\_\_\_\_

 BONE DENSITOMETRY

**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

**Musculoskeletal:**
 Upper Extremity w/ 3D Recons  
 Lower Extremity w/ 3D Recons  
 Rt  Lt  
 Site: \_\_\_\_\_

 Arthrogram (with contrast)

Site \_\_\_\_\_

 Biopsy: (CT guided)

Specify: \_\_\_\_\_

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

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

**EXTREMITIES**
 Specify site: \_\_\_\_\_  
 RT  LT  Bilateral

 Scanogram for leg length  
 Standing/Weight-Bearing  
 Bone Age

 Bone Scan:  
 (with correlating films if medically necessary)

 Whole Body  
 Limited

**SPECT/CT**
 Bone Scan  
 Whole Body OR  Limited

**ULTRASOUND**
 Venous  
 Upper Extremity  
 Lower Extremity  
 RT  LT  Bilateral

**INTERVENTIONAL**
 Consultation for:

 Kyphoplasty  
 Vertebroplasty  
 Other: \_\_\_\_\_

**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.