

**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: _____

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: _____

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) MD 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.

