EMORY DECATUR HOSPITAL Tax ID Number 58-1966795

PS-1052

Imaging Services Scheduling Order Form
FAX orders to: 404.418.8634
Phone: 404.501.7243

Patient Information / Ordering Information

Patient Name: _____ **DOB:** _____ Sex: ❑ M ❑ F SS #: XXX-XX- _____

Home Phone #: _____ **Mobile Phone #:** _____

Insurance: _____ **Policy #:** _____

Are we *ruling out* a specific diagnosis (specify): _____

ICD - _____ **SYMPTOMS / DIAGNOSIS:** _____

Appointment date/time: _____

❑ **Call patient to schedule**
❑ **Patient will call**
❑ **Patient already scheduled**

Should Emory Decatur / Emory Hillandale pre-cert this procedure on behalf of the physician?
❑ **Yes** ❑ **No**
Pre-cert # (if necessary): _____

SPECIAL REQUEST ***(Please check all that apply)***

❑ **STAT call report #:** _____
❑ **FAX # (if different than AutoFAX #):**
❑ **Send films with patient**
❑ **CD images**

CT

Contrast: ❑ **Without** ❑ **With** ❑ **With and without**
❑ **At discretion of Radiologist**

❑ Abdomen ❑ Chest ❑ CTA Chest **(PE)**
❑ Pelvis ❑ High resolution chest ❑ CTA Neck
❑ Renal stone protocol ❑ Head ❑ CTA Head
❑ Pancreatic Protocol ❑ Sinus ❑ Maxillofacial
❑ Triple Phase Liver ❑ Soft tissue neck ❑ CT Enteroclysis
❑ Hematuria Protocol ❑ Low dose lung ❑ AAA protocol **(A/P only)**
❑ Renal Mass Protocol ❑ Cardiac scoring ❑ CTA Dissection **(C/A/P)**
❑ Spine **(specify):** _____
❑ Extremity **(specify)** _____
❑ Other: _____

MRI

Contrast: ❑ **Without** ❑ **With and without**
❑ **At discretion of Radiologist**

❑ MRI brain ❑ Lumbar spine ❑ Knee ❑ Left ❑ Right
❑ MRA brain ❑ Cervical spine ❑ Shoulder ❑ Left ❑ Right
❑ Pituitary ❑ Thoracic spine ❑ Hips ❑ Left ❑ Right
❑ Pelvis ❑ MRCP ❑ Breast Biopsy (MR guided)
❑ Prostate ❑ Enterography ❑ Breast
❑ Abdomen **(Please specify organ):** _____
❑ MR angiography **(specify):** _____
❑ **Other:** _____

Ultrasound

❑ Abdomen ❑ Pelvic ❑ Pelvic with transvaginal
❑ Thyroid ❑ Abdominal wall mass ❑ Cervical lymph node
❑ Renal ❑ Aorta ❑ Testicles
❑ OB ❑ OB with transvaginal ❑ BPP
Extremity **(non vascular-specify):** _____
Other: _____

Nuclear Medicine

❑ Thyroid uptake and scan ❑ Dual isotope heart scan ❑ Lung
❑ Bone Scan: ❑ Whole Body ❑ 3 phase
❑ Gastric Emptying
❑ Renal: ❑ **With** Lasix ❑ **Without** Lasix
❑ Hida Scan ❑ Hida **with CCK**
❑ Thyroid Therapy ❑ Other: _____

PET/CT: _____

Mammography/Breast Ultrasound

Screening mammogram ❑ Bilateral ❑ Unilateral ❑ R ❑ L
Diagnostic mammogram ❑ Bilateral ❑ Unilateral ❑ R ❑ L
Breast ultrasound ❑ Bilateral ❑ Unilateral ❑ R ❑ L
❑ Other: _____
❑ COMPREHENSIVE REFERRAL REQUEST checking this box authorizes Breast Imaging Physicians to schedule additional breast related studies without separate order, including MRI and biopsies.

Bone Density (For osteoporosis)

❑ DEXA Axial Skeleton ❑ Heel Scan
❑ Vertebral Assessment (VFA)

Interventional Radiology (please attach lab specimen sheet)

❑ Arteriogram **(specify type):** _____
❑ Venous procedure **(specify type):** _____
❑ Embolization **(specify type):** _____
❑ Biopsy **(specify type):** _____
❑ Drainage **(specify type):** _____
❑ Other: _____

Routine X-Ray

❑ Chest, PA and lateral (71020) ❑ Flat abdomen (KUB) (74020)
❑ Acute abdominal series (74022) ❑ Cervical spine 4 view (72050)
❑ Thoracic spine (72072) ❑ Lumbar spine 2-3 view (72100)
❑ Bone survey (multiple myeloma or mets) (77075)
❑ Ribs (71100) ❑ **Left** ❑ **Right**
❑ Extremity **(please specify):** _____ ❑ **Left** **Right**
❑ **Other: (CPT Codes Required)** _____

Fluoro

❑ Barium swallow ❑ Barium enema
❑ Barium enema – air contrast ❑ Upper GI series
❑ Small bowel series ❑ Hysterosalpingogram
❑ Arthrogram **(specify site):** _____
❑ Other: _____

GU Tract

❑ IV Pyelogram ❑ Cystogram, voiding ❑ Retrograde Urethrogram
❑ Other: _____

EKG

❑ EKG ❑ Rhythm Strip ❑ Stress Test ❑ Holter monitor
❑ Other: _____

EEG

❑ EEG ❑ Sleep EEG ❑ SSEP ❑ VEP ❑ BHER
❑ Comments: _____

Heart and Vascular

❑ Extremity ❑ Venous blood flow - ❑ Upper ❑ Lower
❑ Carotid ❑ Arterial blood flow - ❑ Upper ❑ Lower
❑ Echocardiogram Specialists: _____
❑ Other: _____

Referring Physician Information

Physician Name (first & last): _____ NPI#: _____

Phone #: _____ Fax #: _____ GA License #: _____

I hereby certify that the services indicated in the above order form are medically necessary.

Physician Signature: _____ **Date:** _____ **Time:** _____