

MRI, CT & US: (434) 982-7130
 Nuclear Medicine: (434) 982-7139
 Mammo & DEXA: (434) 244-4480
 Fax all orders to: (434) 982-8585

RADIOLOGY OUTPATIENT REQUISITION

Preauthorization # _____
(PATIENT REGISTRATION USE ONLY)
 Med. Records No. _____ Account No. _____

PATIENT INFORMATION

Patient Name (Last, First, Middle) _____ Birthdate (Month/Day/Year) _____ Sex _____ Social Security No. _____
 Street Address _____ City _____ State _____ Zip Code _____ Phone No. (____) _____
 Insurance Co. _____ Policy No. _____ Group No. _____ Policy Holder's Name _____ Primary Care Physician _____

ORDER INFORMATION

Date of Order _____ Appointment Date _____ Appointment Time _____ Arrival Time _____
 Routine Stat Expedite Location Main Hospital Outpatient Care Center Proffit Rd.
 Ordering Physician (Printed) _____ Physician Contact/Pager (if after hours) _____ Physician Signature _____
 Reason for Exam/Symptoms: _____ ICD-9 Code _____
 Early Reading Who to call w/ early read: Name _____ # _____

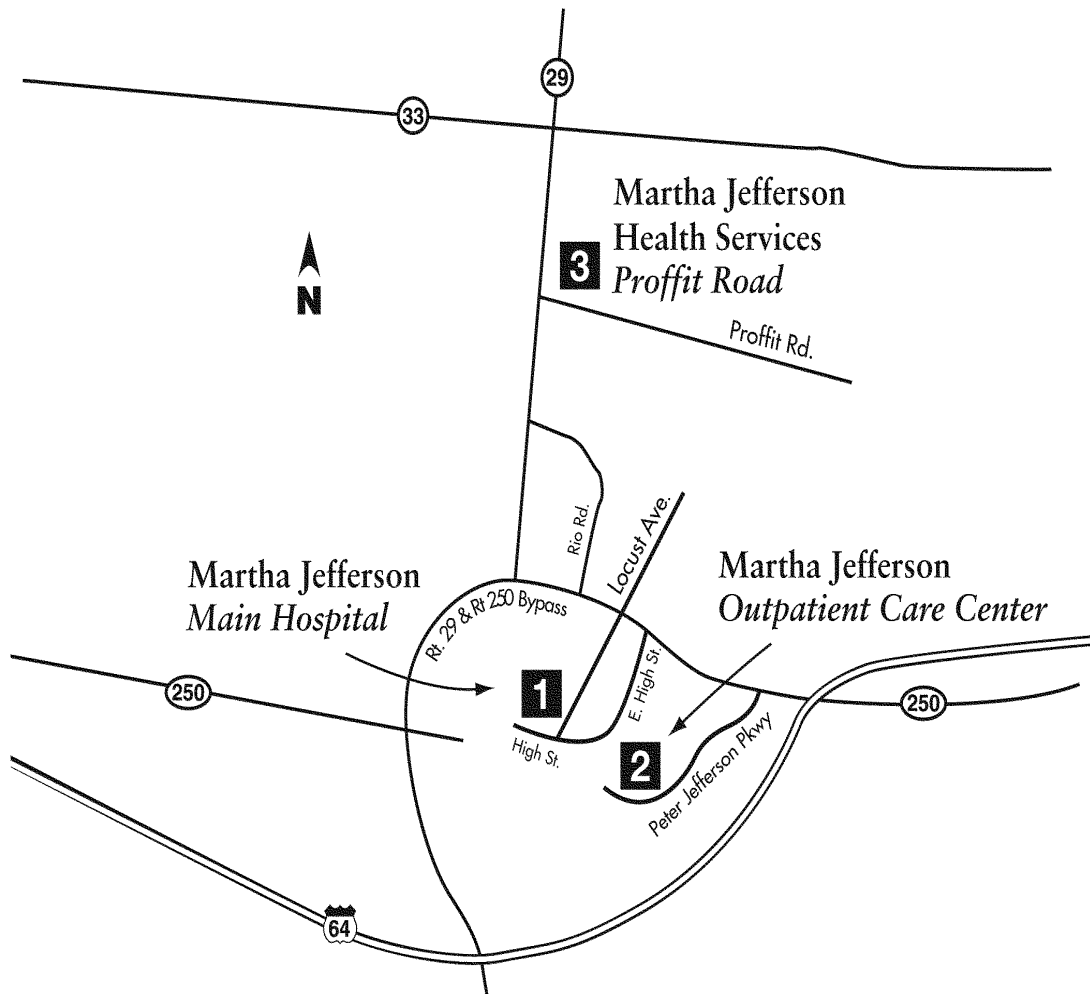
BONE DENSITY	GASTROINTESTINAL TRACT	CT	MRI
<input type="checkbox"/> Dexa	<input type="checkbox"/> Barium Swallow (modified)	Labwork Required:* Y N BUN: _____ CREAT: _____ DATE OF LABS: _____	
CONVENTIONAL RADIOGRAPHY	<input type="checkbox"/> Upper GI	Head/Neck	Brain/Neck (circle contrast)
Chest/Ribs	<input type="checkbox"/> SBFT	<input type="checkbox"/> CT Head without or with	<input type="checkbox"/> MR Brain without or with
<input type="checkbox"/> PA & Lateral	<input type="checkbox"/> Barium Enema Sgl or Dbl	<input type="checkbox"/> CT Orbits	<input type="checkbox"/> MR MS Protocol
<input type="checkbox"/> Ribs w/ PA Chest R or L	GENITOURINARY TRACT	<input type="checkbox"/> CT Soft Tissue Neck	<input type="checkbox"/> MR IAC
Abdomen	<input type="checkbox"/> Intravenous Pyelogram (tomos)	<input type="checkbox"/> CT Sinus Coronal (axials)	<input type="checkbox"/> MR Pituitary
<input type="checkbox"/> Acute Abdominal Series	<input type="checkbox"/> Voiding Cystourethrogram (VCUG)	<input type="checkbox"/> Temporal bones	<input type="checkbox"/> MRA Brain
<input type="checkbox"/> KUB	<input type="checkbox"/> Hysterosalpingogram (HSG)	Thorax	<input type="checkbox"/> MRA Neck
<input type="checkbox"/> Abdomen Supine & Erect	ULTRASOUND	<input type="checkbox"/> CT Chest Angiography	<input type="checkbox"/> MR Soft Tissue Neck
Spine & Pelvis	<input type="checkbox"/> Abdomen, complete	<input type="checkbox"/> CT Coronary Angiography	Spine (circle contrast)
<input type="checkbox"/> C-spine trauma	<input type="checkbox"/> Abdomen, RUQ (specify area)	<input type="checkbox"/> CT Coronary Calcium Scoring	<input type="checkbox"/> MR Cervical without or with
<input type="checkbox"/> C-spine nontrauma	<input type="checkbox"/> Abdomen Aorta	<input type="checkbox"/> CT Thorax [pulm nodule]	<input type="checkbox"/> MR Thoracic without or with
<input type="checkbox"/> Thoracic spine	<input type="checkbox"/> Renal (Kidneys & Bladder)	<input type="checkbox"/> CT Pulmonary Angiogram	<input type="checkbox"/> MR Lumbar without or with
<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/> Gallbladder Function	<input type="checkbox"/> CT Thorax High Resolution	Musculoskeletal (circle R or L)
Upper Extremity (circle R or L)	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Lung Cancer Screening	<input type="checkbox"/> MR Shoulder w/arthrogram R or L
<input type="checkbox"/> Clavicle R or L	<input type="checkbox"/> OB 1st trimester <14 weeks	Abdomen/Pelvis	<input type="checkbox"/> MR Shoulder w/out arthrogram R or L
<input type="checkbox"/> Shoulder R or L	<input type="checkbox"/> OB complete >14 weeks	<input type="checkbox"/> Abd & Pel standard w/ contrast	<input type="checkbox"/> MR Elbow R or L
<input type="checkbox"/> AC Joints R or L	<input type="checkbox"/> OB Follow-up	<input type="checkbox"/> CT Abdomen only	<input type="checkbox"/> MR Wrist R or L
<input type="checkbox"/> Humerus R or L	<input type="checkbox"/> Scrotal	<input type="checkbox"/> CT Pelvis only	<input type="checkbox"/> MR Hand R or L
<input type="checkbox"/> Elbow R or L	<input type="checkbox"/> Thyroid	<input type="checkbox"/> CT Enterography	<input type="checkbox"/> MR Finger (specify digit) R or L
<input type="checkbox"/> Forearm R or L	NUCLEAR MEDICINE	<input type="checkbox"/> CT Liver Mass	<input type="checkbox"/> MR Osseous Pelvis
<input type="checkbox"/> Wrist [scaphoid] R or L	<input type="checkbox"/> Bone Scan WB or limited	<input type="checkbox"/> CT Renal Mass	<input type="checkbox"/> MR Knee R or L
<input type="checkbox"/> Hand R or L	<input type="checkbox"/> Cardiac	<input type="checkbox"/> CT Pancreas Mass	<input type="checkbox"/> MR Ankle R or L
<input type="checkbox"/> Finger (specify digit) R or L	<input type="checkbox"/> Gastric Emptying	<input type="checkbox"/> CT Renal Stone	<input type="checkbox"/> MR Foot R or L
Pelvis/Lower Extremity (circle R or L)	<input type="checkbox"/> HIDA (liver) [w/ EF]	<input type="checkbox"/> CT Urogram	<input type="checkbox"/> MR Toe (specify digit) R or L
<input type="checkbox"/> Pelvis	<input type="checkbox"/> Infection Gallium or Tagged WBC	<input type="checkbox"/> CT Adrenal	<input type="checkbox"/> MR Soft Tissue Mass (specify)
<input type="checkbox"/> Hip R or L	<input type="checkbox"/> Octreoscan	Extremity/Spine (circle one)	Abdomen/Pelvis
<input type="checkbox"/> Femur R or L	<input type="checkbox"/> Parathyroid	<input type="checkbox"/> CT Spine C T L Spine	<input type="checkbox"/> MR Abdomen complete (w/MRCP)
<input type="checkbox"/> Knee R or L	<input type="checkbox"/> PET/CT (PET order form required)	<input type="checkbox"/> CT Myelogram C T L Spine	<input type="checkbox"/> MRCP Only
<input type="checkbox"/> Tibia & Fibula R or L	<input type="checkbox"/> Renal, hypertension (Captopril)	<input type="checkbox"/> CT Upper extremity R or L	<input type="checkbox"/> MRA Abdomen
<input type="checkbox"/> Ankle R or L	<input type="checkbox"/> Renal, obstruction (Lasix)	<input type="checkbox"/> CT Lower extremity R or L	<input type="checkbox"/> MR Renal Mass
<input type="checkbox"/> Foot R or L	<input type="checkbox"/> Thyroid uptake scan therapy	<input type="checkbox"/> CT Osseous Pelvis	<input type="checkbox"/> MR Female Pelvis / MR Prostate
<input type="checkbox"/> Toe (specify digit) R or L			<input type="checkbox"/> MR Breast

3D Reconstruction as Medically Necessary Contrast at Discretion of Radiology

OTHER	VASCULAR/INTERVENTIONAL	
	Vascular	NonVascular
<input type="checkbox"/> _____	<input type="checkbox"/> Venous:	
<input type="checkbox"/> _____	<input type="checkbox"/> Arterial:	

* CT and MRI w/IV Contrast: BUN and CREATININE must be obtained for the following patients prior to their appointment: over the age of 65, history of diabetes, renal insufficiency, history of hypertension, or history of severe hepatic disease (for MRI only). Lab values obtained within 6 weeks of scheduled exam are acceptable.

Patients: Unless otherwise noted, please plan to arrive at least **30 minutes prior** to your appointment time.



Martha
Jefferson Medical Imaging

www.mjhmedicalimaging.org