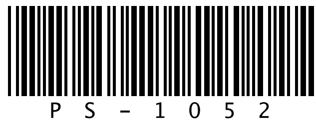
DeKalb Medical
Tax ID Number 58-1966795



Imaging Services Scheduling Order Form
FAX orders to: 404.501.1743
Phone: 404.501.2660

Patient Information / Ordering Information

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

Home Phone #: ____________ **Mobile Phone #:** ____________

Insurance: ____________ **Policy #:** ____________

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

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

ICD - ________ **SYMPTOMS / DIAGNOSIS:** ____________

Appointment date/time: ____________

Should DeKalb Medical 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: ____________

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: ____________

PROOF #2

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:** ____________