



Patient Information – FRONT (Page 1 of 2)

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: _____

SPECIAL REQUEST (Please check all that apply)

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

- Call patient to schedule
 Patient will call
 Patient already scheduled

Should DeKalb Medical pre-cert this procedure on behalf of the physician?
 Yes No

Pre-cert # (if necessary): _____

Cat Scan (CT)

Head / Face / Neck

- CT Head W/O (70450) W & W/O (70470)
 CTA Head (70496) CT Sinus w/o (70486)
 Maxillofacial w/o (70486) Temporal (70480)
 Soft tissue neck with (70491) CTA Neck (70498)

CT Chest:

- Chest with (71260) Without (71250)
 PE Protocol (71275)
 Hi Resolution Chest w/o (71250)
 Low Dose Lung Cardiac/Calcium Scoring (75571)

CT Abdomen / Pelvis:

- Abdomen With (74160) Without (74150)
 Abdomen & Pelvis with (74177) Without (74176)
 Pelvis With (72193) Without (72192)
 CTA Abdomen and Pelvis with (74174)

Abdomen / Pelvis Protocols:

- Renal Stone Protocol (71476)
 Pancreatic Protocol (74170)
 Renal MASS Protocol (74170, 72193)
 3 Phase Liver (74170)
 Hematuria (74178)
 CT Enteroclysis (74177)
 AAA Protocol – Abdomen/Pelvis with (74174)
 Dissection (Chest/Abd/Pelvis) (71275/74174)

CT Spine / Extremity

- Cervical w/o (72125) Thoracic w/o (72128)
 Lumbar w/o (72131)
 Lower Extremity w (73701) Lower extremity w/o (73700)
 Upper Extremity w/ Upper Extremity w/o

Specify body part: _____

- LEFT RIGHT

MRI

Brain / Neck / Orbit

- Brain W/O (70551) W & WO (70553)
 Orbit / Face / Neck W/O (70540) W & WO (70543)
 MRA/MRV Brain (70544) MRA Neck W & W/O (70549)
 IAC (70553) Pituitary (70553)

Spine

- Cervical spine W/O (72141) W & W/O (72156)
 Thoracic spine W/O (72146) W & W/O (72157)
 Lumbar Spine W/O (72148) W & W/O (72158)

Breast

- Breast Bilateral with and without (77059)
 Breast Biopsy (19085): _____

Abdomen/Pelvis:

- Abdomen WO (74181) W & W/O (74183)
 Pelvis W/O (72195) W & W/O (72197)
 Prostate (72197)
 MRCP (74181) Enterography (74183,72197)

Upper Extremity JOINT:

- LEFT RIGHT Without (73221) W & WO (73223)
 Shoulder Elbow Wrist

Upper Extremity NON- JOINT-

- LEFT RIGHT Without (73218) W & WO (73220)
 Humerus Forearm Hand

Lower Extremity JOINT:

- LEFT RIGHT Without (73721) W & WO (73723)
 Hip Knee Ankle

Lower Extremity NON- JOINT-

- LEFT RIGHT Without (73718) W & WO (73720)
 Femur Tib-Fib Foot

OTHER: _____ CPT: _____

Ultrasound

- Abdomen(76700) Abdominal wall mass (76705) Renal (76705) Prostate (76872)
 Sonohysterogram (76831) Aorta (76770) Pelvic (76856) Pelvic with transvaginal (76856/76830)
 Thyroid (76536) Cervical lymph node Testicles (76870)
 BPP (76819) OB follow-up (76816) OB >14 weeks (76805) OB < 14weeks (76801)
 OB with endovaginal <14 weeks (76817,76801) OB follow-up with endovaginal (76817,76816)

Extremity: Non vascular: _____ **Other:** _____ **CPT:** _____

Physician Name (first & last): _____ **NPI#:** _____ **GA License #:** _____

Physician Address: _____ **Phone #:** _____ **Fax #:** _____

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

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



Patient Information – BACK PAGE 2

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ICD - _____ SYMPTOMS / DIAGNOSIS: _____

Appointment Date/Time: _____

SPECIAL REQUEST (Please check all that apply)

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 Patient will call
 Patient already

Should DeKalb Medical pre-cert this procedure on behalf of the physician?
 Yes No

Pre-cert # (If necessary):

Interventional Radiology (please attach lab specimen sheet)

- Thoracentesis (32555) Paracentesis (49083)
 Port Placement (36561) Port Removal (36590)
 Thyroid FNA (10022,76942) Ash Cath Place (36581)

CT Guided Biopsy (77012 - CT Guidance)

- LUNG biopsy (32405) LIVER biopsy (47000)
 RENAL biopsy (50200) PANCREATIC (48102)
 BONE MARROW (38221)
 Other Biopsy: _____
 Drainage: _____

US Guided Biopsy (76942 – US Guidance)

- LIVER biopsy (47000)
 Other: _____

- UFE (37243): _____
 Vertebroplasty Cervicothoracic (22510)
 Vertebroplasty Lumbosacral (22511)
 Kyphoplasty Thoracic (22513)
 Kyphoplasty Lumbar (22514)
 Radiologist Consult (99211) _____
 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 (74220) Upper GI (74240)
 Small bowel series (74250)
 Barium enema – air contrast (74280) Barium Enema (74270)
 Hysterosalpingogram (74740/58340)
 Lumbar Puncture (62270) Port Study (36598)
 Myelogram Cervical (62302) Myelogram Lumbar (62304)
 Cystogram(74430) Cystogram (Voiding) (74455)
 Retrograde Urethrogram (51610)
 Arthrogram (specify site/CPT): _____
 Other: _____

PET/CPT : _____

Mammography/Breast Ultrasound

- Screening mammogram (77057)
Diagnostic mammogram
 Bilateral (77056) Unilateral (77055) R L
Breast ultrasound
 Bilateral Unilateral (76641) R L
Biopsy
 Stereotactic Biopsy (19081) US Guided Biopsy (19083)
 Breast Localization (mammo) (19281)
 Other: _____
CPT: _____
Bone Density (For osteoporosis)
 DEXA Axial Skeleton (77085) Heel Scan
 Vertebral Assessment (VFA) (77086)

Heart and Vascular

- EKG (93000) Rhythm Strip (93041) Stress Test (93017)
 Holter Monitor (93225) Echocardiogram (93306)
 Upper Extremity Venous Doppler: Left Right
 Upper Extremity Venous Doppler – Bilateral
 Venous blood flow Upper Lower
 Carotid blood flow Upper Lower Carotid (93880)
 Other: _____ **CPT:** _____

Nuclear Medicine

- Bone Scan: Whole Body (78306)
 3 phase (78315) 4 Phase (78300/78315)
 Thyroid uptake and scan I-123 (78014)
 Whole Body I – 131 (78018)
 Thyroid Therapy I- 131 (79005)
 Parathyroid (78070)
 Dual isotope heart scan (78452)
 VQ-Lung (78582) Chest X-ray for VQ (71020)
 Gastric Emptying (78264)
 GI Bleed (78278)
 Renal: **With** Lasix (78708,78709)
 Renal **Without** Lasix (78707)
 Hida Scan(78226) Hida with CCK(78227)
 Octreoscan (78804)
 MUGA Single – (78472) MUGA multi (78473)
 Breast Lympho pre surgery (78808)
 Other: _____

Referring Physician Information

Physician Name (first & last): _____ **NPI#:** _____ **GA License #:** _____

Physician Address: _____ **Phone #:** _____ **Fax #:** _____

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