TULSA ER & HOSPITAL

Diagnostic Imaging Order Form

Patient Information

Name: _____ Date of Birth: ____/____/____ Weight: _____ lb / kg

Insurance/Policy #: _____ Pre-Authorized #/Date Range: _____

Ordering Physician (Please Print):_____ Phone: _____

Physician Signature: _____ NPI #: _____ Date: _____

Clinical Reason for Exam (including ICD 10 codes: _____

_____

Physician Preference for Results: ☐ Report Only ☐ Report and CD ☐ Routine ☐ STAT

Fax: _____ Other: _____

X-Ray	☐ Skull ☐ Orbits ☐ Sinuses ☐ Cervical Spine ☐ Thoracic Spine ☐ Lumbar Spine ☐ Chest (AP & Lat) (PA) ☐ Abdomen ☐ Pelvis ☐ Ribs (Lt)(Rt) ☐ Hip (L)(R) ☐ Extremity/Joint:_____ (Lt)(Rt)(Bilat.) (Upper)(Lower) ☐ Other (specify): _____
CT ☐ Oral Contrast ☐ W/IV Contrast ☐ W/O Contrast ☐ W/ and W/O IV Contrast	☐ Head/Brain ☐ Orbits ☐ Sinus ☐ Neck (Soft Tissues) ☐ Cervical Spine ☐ Thoracic Spine ☐ Lumbar Spine ☐ Chest ☐ Abdomen/Pelvis ☐ Abdomen Only ☐ Pelvis Only ☐ Extremity/Joint:_____ (Lt)(Rt)(Bilat.) (Upper)(Lower) ☐ Other (specify): _____ Creatinine: _____ GFR: _____ Date: _____
MRI ☐ W/IV Contrast ☐ W/O Contrast ☐ W/ and W/O IV Contrast **MRI's must be scheduled**	☐ Brain MRI ☐ Brain MRA ☐ Cervical Spine ☐ Thoracic Spine ☐ Lumbar Spine ☐ Neck MRA ☐ IAC ☐ Orbits ☐ Neck (Soft Tissue) ☐ MRCP ☐ Abdomen ☐ Pelvis ☐ Shoulder (Lt)(Rt) ☐ Hip (Lt)(Rt) ☐ Knee (Lt)(Rt) ☐ Ankle (Lt)(Rt) ☐ Extremity other (specify):_____ (Lt)(Rt)(Bilat.) (Upper)(Lower) ☐ Check Box if claustrophobic ☐ Other (specify): _____ Creatinine: _____ GFR: _____ Date: _____
Ultrasound	☐ Complete Abdomen ☐ Limited Abdomen (specify): _____ ☐ OB/TV - 1st Trimester ☐ Limted OB - Follow ☐ OB - Fetal Bio Physical Profile ☐ Pelvis ☐ Gallbladder ☐ Renal ☐ Bladder ☐ Scrotum ☐ Thyroid ☐ Carotid ☐ Aorta ☐ Venous: ☐ Upper Extremity (Lt)(Rt)(Bilateral) ☐ Lower Extremity (Lt)(Rt)(Bilateral) ☐ Arterial ☐ Upper Extremity (Lt)(Rt)(Bilateral) ☐ Lower Extremity (Lt)(Rt)(Bilateral) ☐ Other (specify): _____

Please email, fax or send patient with completed and signed order.
If possible, include a copy of the patient's insurance card (front and back). Thank you!

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