(855) 327-6003 • Fax: (855) 314-6973

Radiology Order Form

Patient Name: ______________________ Date Ordered: __________

Address: ______________________ DOB: ________ Phone: __________

Male ☐ Female ☐ Insurance Provider: ______________ Insurance ID#: __________

Prior Scan Yes ☐ No ☐ *(If patient had prior scan, please attach.)*

PLEASE ATTACH COPY OF INSURANCE CARDS AND RECENT OFFICE VISIT NOTE WITH THIS FORM

Requested Date of Exam: ______________ ICD-10 Codes: ______________

Reason for Exam: ______________________________

PET/CT SCAN: Please select: ☐ Initial Treatment Strategy ☐ Restaging

☐ Skull Base to Mid-Thigh
☐ Whole Body (For Melanoma, Multiple Myeloma, Merkel Cell)
☐ Axumin Skull to Mid-Thigh
☐ Pet Brain- Metabolic FDG
☐ Florbetapir F18 PET Scan (Gladiolus Only)
☐ Detectnet (Cu64) Scan
☐ NAF-18 (Bone) Scan Whole Body
☐ Pylarify - PSMA (Certain Locations)

CT SCAN: All CT scans require a Creatinine and EGFR level within the last 30 days for patients with diabetes and/ or kidney Issues.

Abdomen
☐ With ☐ W/O ☐ With & W/O
Oral Contrast

Cervical Spine
☐ With ☐ W/O ☐ With & W/O
Oral Contrast

Chest, Abdomen, Pelvis
☐ With ☐ W/O ☐ With & W/O
Oral Contrast

Maxillofacial
☐ With ☐ W/O ☐ With & W/O
Oral Contrast

Thoracic Spine
☐ With ☐ W/O ☐ With & W/O
Oral Contrast

Abdomen Triple Phase
W Pelvis W Contrast
☐ With ☐ W/O ☐ With & W/O
Oral Contrast

Abdomen, Pelvis
☐ With ☐ W/O ☐ With & W/O
Oral Contrast

Chest
☐ With ☐ W/O ☐ With & W/O
Oral Contrast

Lower Extremity
☐ With ☐ W/O ☐ With & W/O
☐ Left ☐ Right ☐ Upper
☐ Lower ☐ Both ☐ Oral Contrast

Neck
☐ With ☐ W/O ☐ With & W/O
Oral Contrast

Upper Extremity
☐ With ☐ W/O ☐ With & W/O
☐ Left ☐ Right ☐ Upper
☐ Lower ☐ Both ☐ Oral Contrast

Brain
☐ With ☐ W/O ☐ With & W/O
Oral Contrast

Chest, Abdomen
☐ With ☐ W/O ☐ With & W/O
Oral Contrast

Lumbar Spine
☐ With ☐ W/O ☐ With & W/O
Oral Contrast

Pelvis
☐ With ☐ W/O ☐ With & W/O
Oral Contrast

Abdomen Triple Phase
☐ With & W/O
Oral Contrast

ALLERGY TO IODINE
☐ Yes ☐ No
Allergy Med Given: __________

____
Referring Physician Name

____
Phone #

____
Signature

____
Fax #