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CT Imaging Order Form

Revision 05-28-2024

Date Imaging Needed: _____ ***Scans to be completed up to 10 days prior***

***If Research** Study Name: _____ Subject ID _____ Study Time Point: _____

PATIENT INFORMATION

Patient Name:			DOB:	
Patient Height:		Patient Weight:		*(lbs)*
Gender: ☐ Male ☐ Female		Patient Phone #:		
Patient Ambulatory: ☐ Yes ☐ No		Assistance Needed:		

ORDER INFORMATION

STAT Read:	☐ Yes ☐ No	Insurance Authorization #:		ICD10 Code:	
Billing:	☐ Research ☐ Patient Insurance:				

If image(s) are desired to be transferred to a health system please indicate here

Facility Name:		Facility Phone #:	

OPTIONAL INFORMATION

Recent Surgery / Biopsy (Site/Approximate Date):					
Has the patient had previous imaging studies on this area of the body?	☐ Yes ☐ No				
Facility Performed:					
Does the patient have a known contrast allergy:	☐ Yes ☐ No ☐ Unknown				
Contrast Prep Given:	☐ Yes ☐ No				
Patient Diabetic:	☐ Yes ☐ No	Medication Taken:	☐ None (Diet) ☐ Insulin ☐ Oral Meds		

REFERRING PROVIDER INFORMATION

Ordering Provider Name:					
Provider NPI:		Phone:		Fax:	
Additional Copies of Report to:				Fax:	

SPECIFIC REASON FOR STUDY

Complaint / Signs and Symptoms:	
Rule Out:	

STUDY REQUESTED

☐ Abdomen ☐ Cervical Spine ☐ Thoracic Spine ☐ Lumbar Spine ☐ Thorax (Chest) ☐ Head ☐ Temporal Bone ☐ Orbit ☐ Pelvis ☐ Maxillofacial ☐ Sinuses ☐ Soft Tissue Neck ☐ Other: _____	☐ Lower Extremity, Left ☐ Lower Extremity, Right ☐ Upper Extremity, Left ☐ Upper Extremity, Right ☐ CTA Abdomen & Pelvis ☐ CTA Abdominal Aorta & Le Runoff ☐ CTA Abdomen ☐ CTA Chest (PE Protocol) ☐ CTA Head ☐ CTA Lower Extremity Left ☐ CTA Lower Extremity Right ☐ CTA Neck ☐ CTA Upper Extremity Left ☐ CTA Upper Extremity Right	☐ w/Contrast ☐ IV ☐ Oral ☐ w/o Contrast ☐ w/ & w/o Contrast

Please Provide any additional Comments:

PROVIDER SIGNATURE: _____ **DATE:** _____