Diag Outpatient OF.pdf 3/10/2007 8:49:25 AM

Diagnostic Outpatient Order Form-PLEASE BRING THIS LEGAL DOCUMENT TO YOUR APPOINTMENT

PLEASE PRINT

Patient Legal Name:_____ **Date of Birth:**_____

Last **First** **MI** **MM** **DD** **YY**

Social Security # :_____ **Primary Cardholder's Name:**_____

Insurance Company:_____ **Policy # :**_____

Date **Arrival Time** **Test Time** **Patient Instruction** __NPO after midnight __No Prep __P/U prep kit or oral contrast __Other	**Procedure Name:** **Medical Necessity: (Signs & Symptoms)** **Special Instructions:** ____**Nuclear Medicine Bone Scan: Perform additional plain films, if necessary**	Check only ONE if applicable to the test: _____Contrast per Radiologist discretion _____No IV Contrast _____With IV Contrast _____With and without IV Contrast _____With reconstructive views BUN_____result Creatinine_____result Date drawn _____/_____/_____ Lab work drawn at_____ _____To be drawn at facility prior to test. *Need within 30 days prior to procedure
Date **Arrival Time** **Test Time** **Patient Instruction** __NPO after midnight __No Prep __P/U prep kit or oral contrast __Other	**Procedure Name:** **Medical Necessity: (Signs & Symptoms)** **Special Instructions:** ____**Nuclear Medicine Bone Scan: Perform additional plain films, if necessary**	Check only ONE if applicable to the test: _____Contrast per Radiologist discretion _____No IV Contrast _____With IV Contrast _____With and without IV Contrast _____With reconstructive views BUN_____result Creatinine_____result Date drawn _____/_____/_____ Lab work drawn at_____ _____To be drawn at facility prior to test. *Need within 30 days prior to procedure
Date **Arrival Time** **Test Time**	**MAMMOGRAPHY** **Screening Mammogram** **___Bilateral** **___Right ___Left** **Baseline Mammogram** **___Bilateral** **___Right ___Left** **Diagnostic Mammogram** **___Bilateral** **___Right ___Left**	IMPLANTS? _____Yes _____No Prior Films? _____Yes _____No Film Location & Date:_____ Check if applicable ___Perform/Schedule ultrasound if mass or density present ___Perform/Schedule aspiration if cystic mass present ___Perform/Schedule biopsy, if indicated

Physicians/PA/APRN Signature_____ **Date:**_____

Name of Sponsoring Physician_____ **Report copy to:**_____

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Advanced Medical Imaging is located on the south side of Pioneers Blvd. between 70th and 84th Streets.

Advanced MEDICAL IMAGING

Radiology Associates, P.C.