

IMAGING ORDER FORM
for Physicians Outside of NJH

Imaging Hours Monday - Friday 7:00 AM - 6:00 PM

Scheduling # 303-270-2420
Fax# 303-270-2501

Special Requests: Phone Report CD with patient

To better facilitate scheduling of your patient, please fax a demographic face sheet along with the order.

Patient Name: _____ Date of Birth: _____

Home Phone: _____ Cell/Work Phone: _____

Insurance Provider: _____ **Precert** No / Yes # _____

Ordering Physician's Name: _____ Phone # _____

Physician's Address: _____ Fax # _____

Contact Name: _____

Diagnosis: _____ Symptoms: _____

Reason for Exam: _____

All CT & MRI studies with IV contrast require a Creatinine level within 30 days prior to exam. Creatinine: _____ Date: _____

A Creatinine will be done at the time of exam at NJH with Point of Care testing if creatinine is not available .

MRI		
<p style="text-align: center;">Head & Neck</p> <p><input type="checkbox"/> Brain w/o 70551</p> <p><input type="checkbox"/> Brain w/o & w contrast 70553</p> <p style="padding-left: 20px;"><input type="checkbox"/> IAC w/o & w</p> <p style="padding-left: 20px;"><input type="checkbox"/> Pituitary w/o & w</p> <p><input type="checkbox"/> Orbit w/o & w contrast 70543</p> <p><input type="checkbox"/> Soft Tissue Neck w/o 70540</p> <p><input type="checkbox"/> Soft Tissue Neck w/o & w 70543</p> <p><input type="checkbox"/> Temporomandibular Joint 70336</p> <p style="text-align: center;">Upper Extremity Non-Joint</p> <p><input type="checkbox"/> Humerus <input type="checkbox"/> Forearm <input type="checkbox"/> Hand</p> <p style="padding-left: 40px;">R___ L___</p> <p>___ w/o 73218 ___ w/o & w 73220</p> <p style="text-align: center;">Lower Extremity Non-Joint</p> <p><input type="checkbox"/> Thigh <input type="checkbox"/> Calf <input type="checkbox"/> Foot</p> <p style="padding-left: 40px;">R___ L___</p> <p>___ w/o 73718 ___ w/o & w 73720</p> <p style="text-align: center;">Cardiac</p> <p><input type="checkbox"/> Cardiac for Morphology/Function ___ w/o 75557 ___ w/o & w/contrast 75561</p> <p><input type="checkbox"/> Cardiac Velocity Flow Mapping 75565 <input type="checkbox"/> Stress Cardiac w/o & w/contrast 75563</p>	<p style="text-align: center;">Spine & Chest</p> <p><input type="checkbox"/> Cervical w/o 72141</p> <p><input type="checkbox"/> Cervical w/o & w contrast 72156</p> <p><input type="checkbox"/> Thoracic w/o 72146</p> <p><input type="checkbox"/> Thoracic w/o & w contrast 72157</p> <p><input type="checkbox"/> Lumbar w/o 72148</p> <p><input type="checkbox"/> Lumbar w/o & w contrast 72158</p> <p><input type="checkbox"/> Chest w/o 71550</p> <p><input type="checkbox"/> Chest w/o & w contrast 71552</p> <p style="text-align: center;">Upper Extremity Joint</p> <p><input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist</p> <p style="padding-left: 40px;">R___ L___</p> <p>___ w/o 73221 ___ w/o & w 73223</p> <p style="text-align: center;">Lower Extremity Joint</p> <p><input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle</p> <p style="padding-left: 40px;">R___ L___</p> <p>___ w/o 73721 ___ w/o & w 73723</p>	<p style="text-align: center;">Abdomen & Pelvis</p> <p><input type="checkbox"/> Abdomen w/o 74181</p> <p style="padding-left: 40px;"><input type="checkbox"/> MRCP w/o</p> <p><input type="checkbox"/> Abdomen w/o & w 74183</p> <p><input type="checkbox"/> Abd. & Pelvis Enterography w/o & w 74183 & 72197</p> <p><input type="checkbox"/> Pelvis w/o 72195</p> <p><input type="checkbox"/> Pelvis w/o & w contrast 72197</p> <p style="text-align: center;">MRA</p> <p><input type="checkbox"/> MRA Head w/o 70544</p> <p><input type="checkbox"/> MRA Neck w/o & w 70549</p> <p><input type="checkbox"/> MRA Chest w/o & w 71555</p> <p><input type="checkbox"/> MRA Abd. w/o & w contrast 74185</p> <p><input type="checkbox"/> MRA Pelvis w/o & w contrast 72198</p> <p><input type="checkbox"/> MRA Upper Extremity w/o & w 73225</p> <p><input type="checkbox"/> MRA Lower Extremity w/o & w 73725</p>

MRI Screening Questions

Contact MRI staff if any of the answers are yes, MRI may be contraindicated 303-398-1611

<p><input type="checkbox"/> Cardiac Pacemaker, ICD</p> <p><input type="checkbox"/> Neurostimulator or other implanted system</p> <p><input type="checkbox"/> Cochlear ear implant</p> <p><input type="checkbox"/> Aneurysm clip (Manufacturer and model type needed)</p> <p><input type="checkbox"/> Hx- Injury to eye by metal fragment? <i>If yes, an orbit x-ray may be required prior to the MRI</i></p>	<p><input type="checkbox"/> Electronic or magnetically activated implant</p> <p><input type="checkbox"/> Implanted drug infusion device</p> <p><input type="checkbox"/> Pregnant</p> <p><input type="checkbox"/> Weight over 350 lbs (The magnet bore is 60cm wide)</p>
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Physician's Signature: _____ **Date:** _____

PET/CT

- PET/CT Skull to mid-Thigh 78815 PET/CT Whole Body 78816
- _____Oncology _____Infection _____Infection _____Oncology (For Melanoma & Lymphoma only)
- PET/CT Myocardial Metabolic 78459 _____Sarcoid Imaging

CT Scan

- | | | |
|--|--|--|
| <input type="checkbox"/> Chest w/o- HRCT/Extend 71250 | <input type="checkbox"/> Abdomen w/o 74150 | <input type="checkbox"/> Head w/o 70450 |
| <input type="checkbox"/> Chest w/contrast 71260 | <input type="checkbox"/> Abdomen w/contrast 74160 | <input type="checkbox"/> Head w/contrast 70460 |
| <input type="checkbox"/> Chest Cancer Screen 71250 | <input type="checkbox"/> Abdomen w/o & w 74170 | <input type="checkbox"/> Neck w/o 70490 |
| <input type="checkbox"/> CTA Chest-PE w/contrast 71275 | <input type="checkbox"/> Abd/Pelvis w/o 74176 | <input type="checkbox"/> Neck w/contrast 70491 |
| <input type="checkbox"/> CTA Aorta w/o Runoff 71275 | <input type="checkbox"/> Abd/Pelvis w/contrast 74177 | <input type="checkbox"/> Sinus w/o 70486 |
| <input type="checkbox"/> CTA Abdomen with Runoff 75635 | <input type="checkbox"/> _____ Enterography | <input type="checkbox"/> CTA Head w/contrast 70496 |
| <input type="checkbox"/> Cardiac Calcium Score 75571 | <input type="checkbox"/> Abd/Pelvis w/o & w 74178 | <input type="checkbox"/> CTA Neck w/contrast 70498 |

Additional patient information is needed for the following exam. The program nurse will contact you for this:

- CTA- Cardiac w/contrast (includes a CT Cardiac Calcium Score) 75574
- *The following medications may be given per policy:
Metoprolol 5mg IV PRN and/or Nitroglycerin 0.4mg SL

CT Screening Questions Contact CT staff if any of the answers are yes. 303-398-1611

- If patient is scheduled for IV contrast, is patient currently taking Metformin or Glucophage?
- Pregnant Iodine Allergy

Nuclear Medicine

- VQ Lung Scan/Vent & Perf 78580 Muga/Gated Blood Pool 78481 Hepatpbiliary HIDA 78220__w/o EF__w/ EF
- Bone Imaging Scan 78315 Gastric Emptying 78264 Nuclear Medicine Other:

* For Nuclear Stress Exercise & Pharm Test 78465- Please use the Cardiology order form.

Routine Radiology/ X-Ray Orders

- | | | |
|---|--|---|
| <p>Chest / Sinus Airway</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest 2 view <input type="checkbox"/> Chest Decubitus R___ L___ <input type="checkbox"/> Chest Apical Lordotic <input type="checkbox"/> Ribs R___ L___ 3-V <input type="checkbox"/> Sternum <input type="checkbox"/> Sinus (Waters) 1-View <input type="checkbox"/> Sinus Series 3-View <input type="checkbox"/> Soft Tissue Neck <p>Fluoroscopy</p> <ul style="list-style-type: none"> <input type="checkbox"/> Esophogram <input type="checkbox"/> UGI <input type="checkbox"/> Small Bowel Series <input type="checkbox"/> Tailored Barium Swallow <input type="checkbox"/> Diaphragm/ Sniff Test | <p>Abdomen</p> <ul style="list-style-type: none"> <input type="checkbox"/> Supine <input type="checkbox"/> Supine & Upright <p>Pelvis</p> <ul style="list-style-type: none"> <input type="checkbox"/> SI Joints <input type="checkbox"/> Pelvis 1-view <input type="checkbox"/> Pelvis 2-View <input type="checkbox"/> Hip 2-View R___ L___ <p>Skull</p> <ul style="list-style-type: none"> <input type="checkbox"/> Skull <input type="checkbox"/> Nasal Bones <input type="checkbox"/> TMJ <input type="checkbox"/> Facial Bones <input type="checkbox"/> Eye for foreign body | <p>Upper Extremities</p> <ul style="list-style-type: none"> <input type="checkbox"/> _____ <li style="text-align: center;">Right_____ Left_____ <p>Lower Extremities</p> <ul style="list-style-type: none"> <input type="checkbox"/> _____ <li style="text-align: center;">Right_____ Left_____ <p>Spinal Column</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cervical Spine 3-View w/Odontoid <input type="checkbox"/> Cervical Spine 4-View w/Obliques <input type="checkbox"/> Thoracic Spine 2-View <input type="checkbox"/> Lumbar Spine 3-View <input type="checkbox"/> Lumbar Spine Flex/ Ext <input type="checkbox"/> Sacrum/Coccyx |
|---|--|---|

Bone Density

- BD Dexa (routine) 77080 BD Lat Vert Assessment(LVA) 72010

Ultrasound

- | | | |
|--|--|--|
| <input type="checkbox"/> Abdomen Complete 76700 | <input type="checkbox"/> Duplex Carotid 93880 | <input type="checkbox"/> Unilateral- 93971 Bilateral- 93970 |
| <input type="checkbox"/> Duplex Abdomen RUQ 76705 | <input type="checkbox"/> Duplex Renal Vascular 93976 | <input type="checkbox"/> Duplex Venous Upper Ext ___L ___R |
| <input type="checkbox"/> Duplex Aorta 76775 | <input type="checkbox"/> Renal 76775 | <input type="checkbox"/> Duplex Venous Lower Ext ___L ___R |
| <input type="checkbox"/> Duplex Arterial Groin ___L ___R 76775 | <input type="checkbox"/> Thyroid 76536 | |

Patient Name _____