DiagnosticsCowlesClinic
NavicentHealthBaldwin

Patient Name_____

Date of Birth _____SS# _____

Phone # _____Doctor_____

Appointment Date & Time_____

Authorization/Pre-Cert #_____

# Radiology Test Requisition

Phone: 706-454-2660 Fax: 706-454-2658

***Fasting:*** ☐ ***Yes*** ☐ ***No*** ***Stat:*** ☐ ***Yes*** ☐ ***No***

PROVIDE **SIGNS, SYMPTOMS, DIAGNOSIS,** OR OTHER INFORMATION SUPPORTING THE **MEDICAL NECESSITY** ORDER ***WILL NOT BE COMPLETED*** WITHOUT THIS DOCUMENTATION!

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**ABSENT APPROPRIATE DOCUMENTATION, AN ADVANCE BENEFICIARY NOTIFICATION (ABN) MAY BE ISSUED**

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| **Diagnostic Imaging** | | | | | | | |
| ☐ | Abdomen AP/KUB | ☐ | Facial Bones | ☐ | Nasal Bones | ☐ | Tibia/Fibula |
| ☐ | Abdomen Flat/Erect | ☐ | Femur | ☐ | Orbits | ☐ | Wrist |
| ☐ | Abdomen, Acute | ☐ | Foot | ☐ | Pelvis | ☐ | |
| ☐ | Ankle | ☐ | Forearm | ☐ | Ribs | ☐ | |
| ☐ | Cervical Spine w/obl | ☐ | Hand | ☐ | Scapula | ☐ | |
| ☐ | Cervical Spine soft tissue | ☐ | Hip/Pelvis | ☐ | Shoulder | ☐ | |
| ☐ | Chest, PA | ☐ | Humerus | ☐ | Sinuses | ☐ | |
| ☐ | Chest, PA/LAT | ☐ | IVP | ☐ | Skull | ☐ | |
| ☐ | Clavicle | ☐ | Knee | ☐ | Sternum | ☐ | |
| ☐ | Elbow | ☐ | Lumbar spine | ☐ | Thoracic Spine | ☐ | |
| **CT Scan** | | | | | | | |
| ☐ | Abdomen W | ☐ | Head W | ☐ | Neck Soft Tissue WO | ☐ | Thorax W |
| ☐ | Abdomen W/WO | ☐ | Head W/WO | ☐ | Orbits WO | ☐ | Thorax W/WO |
| ☐ | Abdomen WO | ☐ | Head WO | ☐ | Pelvis W | ☐ | Thorax WO |
| ☐ | Cervical spine WO | ☐ | IAC W/WO | ☐ | Pelvis W/WO | ☐ | Thoracic Spine WO |
| ☐ | CTA Abd/Femoral Run Off | ☐ | IAC WO | ☐ | Pelvis WO | ☐ | Upper Extremity |
| ☐ | CTA Abd/Pelvis | ☐ | Lower Extremity | ☐ | Renal W | ☐ | Other |
| ☐ | CTA Chest | ☐ | Lumbar Spine WO | ☐ | Renal W/WO | ☐ | |
| ☐ | CTA Head | ☐ | Maxi-Facial WO | ☐ | Renal WO | ☐ | |
| ☐ | CTA Neck | ☐ | Neck Soft Tissue W | ☐ | Sinuses WO | ☐ | |
| **Mammography** | | | | | | | |
| ☐ | Bilateral Diagnostic | ☐ | Left Unilateral Screening | ☐ | Right Unilateral Screening | ☐ | Bone Density |
| ☐ | Bilateral Screening | ☐ | Left Unilateral Diagnostic | ☐ | Right Unilateral Diagnostic | ☐ | Other |
| **Ultrasound** | | | | | | | |
| ☐ | Abdomen complete | ☐ | Liver | ☐ | Renal Artery Doppler | ☐ | Other |
| ☐ | Aorta | ☐ | LE Arterial (RT/LT/BIL) | ☐ | Right Upper Quadrant | ☐ | |
| ☐ | Breast (RT/LT/BIL) | ☐ | LE Venous (RT/LT/BIL) | ☐ | Scrotum | ☐ | |
| ☐ | Biliary Track / GB | ☐ | Mesenteric Doppler | ☐ | Soft Neck Tissue | ☐ | |
| ☐ | Bladder | ☐ | OB/TV ($1^{st}$/$2^{nd}$/$3^{rd}$ ) | ☐ | Spleen | ☐ | |
| ☐ | Biophysical Profile | ☐ | Pelvic/TV | ☐ | Thyroid | ☐ | |
| ☐ | Carotid | ☐ | Renal | ☐ | UE Venous (RT/LT/BIL) | ☐ | |
| **MRI** | | | | | | | |
| ☐ | Abdomen WO | ☐ | Cervical Spine WO | ☐ | Lumbar Spine WO | ☐ | Prostate W/WO |
| ☐ | Abdomen W/WO | ☐ | Orbit/Face/Neck WO | ☐ | MRA Head WO | ☐ | Up Ext Joint WO |
| ☐ | Brain WO | ☐ | Low Ext Joint WO | ☐ | MRA Neck WO | ☐ | Up Ext Non Joint WO |
| ☐ | Brain W/WO | ☐ | Low Ext Non Joint WO | ☐ | MRCP | ☐ | Thoracic Spine WO |

**ADDITIONAL TESTS, ORDERS OR INSTRUCTIONS**_____

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**PHYSICIAN'S SIGNATURE:** _____**Date**_____