

Name:	DOB:	Age:
Phone:	Alt Phone:	
Insurance Name:	Provider Ph #:	
ID:	Precert #:	
Group:		
Reason For Exam:	ICD :	
Ordering Physician:		
Office Phone:	Office Fax:	
Send Report to:	Office Fax:	
<input type="checkbox"/> Stat: Call Report To:		

\* IF PATIENT IS PREGNANT, PLEASE SEND TO ANOTHER FACILITY AS AN ALTERNATIVE MAY BE NEEDED

<input type="checkbox"/> SINUSES	<input type="checkbox"/> ABDOMEN W/O	<input type="checkbox"/> PELVIS W/O
<input type="checkbox"/> FACIAL BONES	<input type="checkbox"/> ABDOMEN WITH <input type="checkbox"/> IV <input type="checkbox"/> ORAL <input type="checkbox"/> BOTH	<input type="checkbox"/> EXTREMITY <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT SPECIFY:
<input type="checkbox"/> SOFT TISSUE NECK <input type="checkbox"/> W IV CON <input type="checkbox"/> W/O IV CON	<input type="checkbox"/> ABDOMEN/PELVIS W/O	<input type="checkbox"/> CERVICAL SPINE
<input type="checkbox"/> CHEST <input type="checkbox"/> W IV CON <input type="checkbox"/> W/O IV CON	<input type="checkbox"/> ABDOMEN/PELVIS WITH <input type="checkbox"/> IV <input type="checkbox"/> ORAL <input type="checkbox"/> BOTH	<input type="checkbox"/> THORACIC SPINE
<input type="checkbox"/> CHEST – HIGH RESOLUTION	<input type="checkbox"/> PELVIS WITH <input type="checkbox"/> IV <input type="checkbox"/> ORAL <input type="checkbox"/> BOTH	<input type="checkbox"/> LUMBAR SPINE

**IF EXAM IS ORDERED WITH IV CONTRAST PLEASE FILL OUT NEXT SECTION**

CHECK ALL THAT APPLY TO THE PATIENT		
<input type="checkbox"/> OVER AGE 70	<input type="checkbox"/> HISTORY OF KIDNEY DISEASE	<input type="checkbox"/> KIDNEY TRANSPLANT
<input type="checkbox"/> NEPHRECTOMY	<input type="checkbox"/> FAMILY HX OF KIDNEY DISEASE	<input type="checkbox"/> DIABETES TYPE 1 OR 2
<input type="checkbox"/> MULTIPLE MYELOMA	<input type="checkbox"/> COLLAGEN VASCULAR DISEASE	<input type="checkbox"/> CONGESTIVE HEART FAILURE
<input type="checkbox"/> CARDIOMYOPATHY	<input type="checkbox"/> HYPERURICEMIA	<input type="checkbox"/> HYPERTENSION
<b><i>IF ANY ABOVE APPLY PATIENT WILL NEED A CURRENT BUN, CREATININE, AND GFR</i></b>		
Within the past 30 days		
Test Date:	BUN Result:	Creatinine Result:
		GFR Result:

ORDERING PHYSICIAN SIGNATURE

DATE