



\*RADIOREQST\*



# RADIOLOGY REQUEST FORM Research Study/Special Billing

HR # \_\_\_\_\_

(Scheduler / Technologist: Enter the above HR # in the exam comments section.)

Page 1 of 1

Form Origination Date: 10/07  
Version: 1

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This form may be completed on line. Tab or move cursor to text field and type in text.

For HIPAA Compliance reasons, this form IS NOT TO BE SAVED with patient information. Selecting the PRINT button will clear all information from the note.

Patient Name \_\_\_\_\_

MRN \_\_\_\_\_

PATIENT IDENTIFICATION LABEL

### Patient Status

INPATIENT Room \_\_\_\_\_  OUTPATIENT

### Desired Schedule

Today  
 First Available  
 Date exam desired: \_\_\_\_\_  AM  PM

Interpretation (check one):  Yes  No

Designated Radiologist: \_\_\_\_\_

GRANT # \_\_\_\_\_

GRANT NAME: \_\_\_\_\_

### Radiology Office Use ONLY:

ACCESSION NO: \_\_\_\_\_

DATE / TIME COMPLETED: \_\_\_\_\_

TECHNOLOGIST: \_\_\_\_\_

### Check modality choice

	<input type="checkbox"/> Diag-nostic	<input type="checkbox"/> Peds	<input type="checkbox"/> CT	<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Mammo	<input type="checkbox"/> MRI	<input type="checkbox"/> Nuclear	<input type="checkbox"/> Interven-tional	<input type="checkbox"/> Neuro Interven-tional	<input type="checkbox"/> Bone Density	<input type="checkbox"/> Rutledge Tower (Diagnostics)
Phone	2-9729	2-9729	2-9729	2-9729	2-8439	2-9729	2-6932	2-9271	2-4932	2-9729	6-0222
Outpt Fax	2-9364	2-9364	2-9364	2-9364	6-0233	2-9364	2-1746	2-2672	2-1705	2-9364	6-1006
Inpt Fax	2-4118	2-6414	2-5856	2-9185	6-0233	2-5856	2-1746	2-5551	2-1705	2-9364	

### REQUIRED BEFORE SCHEDULING

Bill IIT Modifier  Bill QV Modifier

(Scheduler / Technologist: input exam code modifier) \_\_\_\_\_

Exam ordered: \_\_\_\_\_

(Note: A written order in the medical record is required for standard of care patients.)

Clinical indications: (List signs & symptoms that reflect medical necessity and enter these signs & symptoms into patient medical record.) UNACCEPTABLE INDICATIONS: "Line/Tube Placement, Pre-Op, Follow-Up, Status-Post, or Rule-Out"

History: \_\_\_\_\_

Attending Physician: \_\_\_\_\_  
(if different from requestor) Last Name, First Name      Pager ID      Phone      Date

Study Coordinator: \_\_\_\_\_  
Pager ID      Phone      Date

Request Form completed by (if different from above): \_\_\_\_\_  
Last Name, First Name, Title

### Patient information for non-invasive studies:

Contrast Allergy:  Yes  No

Creatinine \_\_\_\_\_

Isolation Precautions:  Yes  No

Strict Isolation       Enteric Precautions

Draining / Secretion       Blood / Body Fluids

Respiratory       Contact Isolation

Contrasted Study:  Yes  No

Possible Pregnancy:  Yes  No

LMP \_\_\_\_\_