UNC HEALTH CARE

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UNC Patient Label Here

External Provider UNCH Outpatient Radiology Order Form

HIM#1169

Clinic Name: _____ **Last Name:**_____ **First Name:**_____

Ordering Provider Name:_____ **DOB:**_____ **UNCH MRN** (if avail)**:**_____

Please PRINT Provider Name (signature line is in grey box below) **Insurance Name:**_____

Clinic Contact:_____ **Insurance Member ID #:**_____

Phone:_____ **Insurance authorization/referral #:**_____

Appointment Date:_____ **Time:**_____ **Bill Skilled Nursing Facility** ☐ **Facility Name:** _____

Ordering Provider Signature: I certify that these diagnosis codes support the test ordered and the test(s)are medically necessary.

_____

Date:_____**Time:**_____**(Signature, Date & Time are required fields)**

☐ **Elective: reasonable delay in treatment will not adversely affect the outcome** ☐ **Non-elective**

Medicare will only pay for services that it determines to be reasonable and necessary under section 1862 (a)(1) of the Medicare Law. When ordering tests for which Medicare reimbursement will be sought, physicians should order only those individual tests that are necessary for the diagnosis and treatment of a patient, rather than for screening purposes.

Procedure	Body part to be Imaged (and/or CPT Code)	Contrast			Diagnosis (ICD) Code
		W	WO	W/ WO	
CT		☐	☐	☐	
MRI		☐	☐	☐	
PET					
Nuclear Medicine					
Diagnostic X-RAY/QDR					
Ultrasound					
Fluoroscopy					

Please provide the most relevant signs and/or symptoms: _____

Reason for exam and/or what is suspected or being ruled out?_____

_____

CT Scan Scheduling Questions: If yes to any of the answers please inform Radiology scheduler.

YES NO 1. Has the patient had an allergic reaction to IV contrast?
YES NO 2. Is the patient on any medication containing metformin? (Glucophage)
YES NO 3. Does the patient have a history of diabetes, renal disease, multiple myeloma, lupus or scleroderma?
YES NO 4. Is the patient on IV antibiotics?
YES NO 5. Is the patient taking daily doses of NSAIDs (Advil, Aleve, Celebrex, Lodine, etc)?
YES NO 6. Does the patient have a recent (within 3 months) serum creatinine value? If yes, when?
YES NO 7. Pregnancy?_____ Date of LMP:_____
YES NO 8. Is patient currently on any blood thinners (e.g. Coumadin, Aspirin, Plavix, Eliquis, Xarelto)? If YES/Applicable, most recent INR (1 week) _____

MRI Scheduling Questions: If yes to any of the answers please inform Radiology scheduler.

YES NO 1. Has the patient ever had a cardiac pacemaker, defibrillator, or LifeVest?
YES NO 2. Has the patient had an aneurysm repair? Does the patient have an aneurysm clip(s)?
YES NO 3. Does the patient have an artificial heart valve?
YES NO 4. Does the patient have any mechanical devices, pumps, stents, implants (neurostimulators, cochlear, etc.)?
YES NO 5. Has the patient ever had an eye injury involving metal or been injured by a metallic foreign body? Has the patient ever done any grinding or welding?
YES NO 6. Has the patient had an allergic reaction to IV contrast?
YES NO 7. Pregnancy?_____ Date of LMP:_____