

RADIOLOGY ORDER

MRN:
Patient Name:

(Patient Label)

PHONE: 310-301-6800	FAX: 310-794-9035
<input type="checkbox"/> WESTWOOD	<input type="checkbox"/> SANTA MONICA <input type="checkbox"/> MAN BEACH
<input type="checkbox"/> Ambulatory <input type="checkbox"/> Wheelchair <input type="checkbox"/> Other: _____	
<input type="checkbox"/> SEDATION (IV/Oral)	<input type="checkbox"/> ANESTHESIA

Procedures Requested **(REQUIRED):**

PLEASE PRINT CLEARLY

<input type="checkbox"/> CT _____ (body part) <input type="checkbox"/> With contrast <input type="checkbox"/> Without contrast <input type="checkbox"/> With/without contrast <input type="checkbox"/> CTA coronary w/contrast & calcium score w/o contrast <input type="checkbox"/> CTA coronary w/contrast (CPT: 0146T) <input type="checkbox"/> CT coronary calcification screening w/o contrast	<input type="checkbox"/> Mammo: Screening <input type="checkbox"/> BILATERAL <input type="checkbox"/> LT <input type="checkbox"/> RT <input type="checkbox"/> Mammo: Diagnostic <input type="checkbox"/> BILATERAL <input type="checkbox"/> LT <input type="checkbox"/> RT <input type="checkbox"/> Breast Ultrasound <input type="checkbox"/> BILATERAL <input type="checkbox"/> LT <input type="checkbox"/> RT Breast implants: <input type="checkbox"/> BILATERAL <input type="checkbox"/> LT <input type="checkbox"/> RT <input type="checkbox"/> MRI Breast (Bilateral) with & w/out contrast (CPT: 77059)
MRI _____ (body part) <input type="checkbox"/> W&WO <input type="checkbox"/> WO MRA _____ (body part) <input type="checkbox"/> W&WO <input type="checkbox"/> WO <input type="checkbox"/> MR Cardiac Function Complete with & w/out contrast and late enhancement (CPT: 75561)	<input type="checkbox"/> Ultrasound _____ (body part) <input type="checkbox"/> Venous Reflux (Unilateral) (CPT: 93971) <input type="checkbox"/> Venous Reflux (Bilateral) (CPT: 93970)
<input type="checkbox"/> Implants _____ (type of)	<input type="checkbox"/> Xray _____ (body part) <input type="checkbox"/> Fluoroscopy (specify study): _____

DIAGNOSIS (REQUIRED):

Adult Peds

CLINICAL HISTORY PERTINENT TO THIS RADIOLOGY CONSULTATION (REQUIRED):

IV ACCESS:

Peripheral Central PICC Line

GAUGE:

SITE:

PRECAUTIONS/ALLERGIES (REQUIRED): (Iodine, IV contrast, latex, etc.)

Serum Creatinine for CT, Angio, MRI w/gado, IVP (Value & Date):

REQUESTING PHYSICIAN NAME	ID / BEEPER	PHONE
		()
ATTENDING PHYSICIAN (must add if requesting MD is a resident/fellow)	UCLA ID/BEEPER (req)	NON-UCLA MD STATE LICENSE (req)

SEND ADDITIONAL REPORT TO:	FAX NUMBER
NAME:	()
ADDRESS (STREET, CITY, STATE):	ZIP CODE:

OFFICE CONTACT: _____ **OFFICE PHONE:** _____ **FAX:** _____

PATIENT INSURANCE: _____ PPO HMO POS OTHER: _____

INSURANCE PRECERTIFICATION AND/OR AUTH#: _____ **EXPIRATION:** _____

APPROVED BY: _____ **INSUR. PHONE:** _____

PHYSICIAN SIGNATURE: _____ **DATE:** _____ **TIME** _____