



Prime
MEDICAL IMAGING

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PATIENT'S NAME: _____

PATIENT'S PHONE#: _____ DOB: _____

PHYSICIAN: _____

CLINICAL HISTORY/INDICATION: _____

RQI #/Pre-certification: _____

Date: _____

ICD-10: _____

cc/NAME: _____ FAX NUMBER: _____

PHYSICIAN'S SIGNATURE: _____

If clinical decision support (CDS) software utilized, please specify vendor and approval: _____

PERTINENT CLINICAL DIAGNOSIS REQUIRED

PLEASE PROVIDE SPECIFIC ICD-10 CODES AND WHEN POSSIBLE:

SYMPTOMS, LOCATION, DURATION, AND PERTINENT PAST HISTORY. (PLEASE DO NOT USE "RULE OUT", "POSSIBLE", ETC.)

COMMENTS: _____

INTRAVENOUS CONTRAST PER RADIOLOGIST (IF YOU DO NOT SELECT THIS OPTION, PLEASE SELECT A CONTRAST OPTION WHERE APPLICABLE.)

ON-SITE BUN/CR TESTING IF NEEDED

MRI	ULTRASOUND	X-RAY	CT SCAN
wo w/wo BRAIN	ABDOMEN COMPLETE	ORBITS for MRI	wo w/wo w BRAIN
w/wo IAC'S	LIVER/GB/PANCREAS (RUQ)	CHEST PA & LATERAL	wo w/wo w ORBITS
w/wo BRAIN & IAC'S	KIDNEY/BLADDER	ABDOMEN <input type="checkbox"/> SUPINE <input type="checkbox"/> SUPINE/UPRIGHT	wo SINUSES
w/wo PITUITARY	THYROID	3 5 F/E CERVICAL SPINE	wo FACIAL BONES
w/wo ORBITS	SCROTAL/TESTICULAR	THORACIC SPINE	w/wo w NECK SOFT TISSUE
B BREAST	PELVIC TRANSABD & TRANSVAG	3 5 F/E LUMBAR SPINE	wo w CHEST
wo w/wo CERVICAL SPINE	CAROTID DOPPLER	SCOLIOSIS	w PE CHEST (CTA)
wo w/wo THORACIC SPINE	AORTA	BONE AGE (L HAND)	wo w/wo w ABDOMEN / PELVIS
wo w/wo LUMBAR SPINE	R L B LE ARTERIAL DOPPLER	JOINTS AND EXTREMITIES	wo RENAL STONE STUDY
R L w/wo BRACHIAL PLEXUS	R L B LE VENOUS DOPPLER	R L B _____	w/wo CT UROGRAM
wo INTRACRANIAL MRA	UE LE MUSCULOSKELETAL STUDY	R L B _____	CERVICAL SPINE
wo w/wo CAROTID/NECK MRA	ANKLE BRACHIAL INDEX (ABI)	R L B _____	THORACIC SPINE
w/wo THORACIC AORTA MRA	OBSTETRIC	X-RAY OTHER:	LUMBAR SPINE
w/wo ABDOMINAL AORTA/RENAL MRA	<input type="checkbox"/> 1st Trimester w EV if needed	_____	R L B SHOULDER/ELBOW/WRIST
w/wo UE/LE PERIPHERAL MRA	<input type="checkbox"/> 2nd/3rd Trimester	_____	R L B HIP/KNEE/ANKLE/FOOT
wo w/wo NECK SOFT TISSUE	<input type="checkbox"/> OB other: _____	_____	3D RECONSTRUCTION
wo w/wo CHEST			CT CALCIUM SCORE
wo w/wo ABDOMEN	MUSCULOSKELETAL	POST-OP JOINT AND SPINE CT SCAN (Metal Suppression Technique)	CT ANGIOGRAPHY (CTA)
<input type="checkbox"/> LIVER <input type="checkbox"/> PANCREAS/MRCP	R L HIP <input type="checkbox"/> with arthrogram	R L SHOULDER	CAROTID/NECK CTA
<input type="checkbox"/> RENAL	R L SHOULDER <input type="checkbox"/> with arthrogram	R L KNEE	THORACIC AORTA CTA
<input type="checkbox"/> ABDOMEN OTHER: _____	R L ELBOW <input type="checkbox"/> with arthrogram	R L HIP	ABDOMINAL AORTA CTA
	R L WRIST <input type="checkbox"/> with arthrogram	R L FOOT/ANKLE	LE UE PERIPHERAL CTA
wo w/wo PELVIS	R L HIP OSSEOUS & PELVIS		INTRACRANIAL CTA
<input type="checkbox"/> BONY <input type="checkbox"/> SI JOINTS	R L KNEE <input type="checkbox"/> with arthrogram	SPINE	
<input type="checkbox"/> UTERUS/OVARIES	R L LEG (TIBIA/FIBULA)	<input type="checkbox"/> CERVICAL	
<input type="checkbox"/> PROSTATE	R L ANKLE/HINDFOOT	<input type="checkbox"/> THORACIC	
<input type="checkbox"/> HERNIA PROTOCOL	R L FOREFOOT	<input type="checkbox"/> LUMBAR	
<input type="checkbox"/> SOFT TISSUES SPECIFY: _____	R L ()		COMMENTS:

PRIORITY READING - Please provide contact telephone number (_____)