West Stanly Imaging

A partner with
Carolinas Medical Center

103 Stanly Parkway, Suite E Locust, NC 28097

T (704) 781-0003 **F** (704) 781-0030

DIAGNOSTIC AND INTERVENTIONAL IMAGING

PATIENT MUST BRING THIS ORDER WITH THEM

PATIENT INFORMATION

PATIENT NAME | D.O.B.

HOME PHONE NUMBER

APPOINTMENT DATE & TIME:

(PATIENTS ARE ASKED TO ARRIVE 15 MINUTES PRIOR TO APPOINTMENT TIME IN ORDER TO REGISTER)

AUTHORIZATION #

PHYSICIAN (Please Print)

CLIENT / OFFICE

SEND COPY OF REPORT TO

DIAGNOSIS & HISTORY _____

☐ **CALL REPORT & HOLD PATIENT** _____

☐ **CALL REPORT/RETURNING TO OFFICE** _____

☐ **FAX REPORT** _____

GENERAL

- ☐ Chest (PA/LAT) ☐ Chest One View
- ☐ Abdomen ☐ Abd series (w/chest)
- ☐ Pelvis ☐ Hip/Pelvis R / L
- ☐ C-spine series ☐ T-spine
- ☐ L-spine series ☐ Femur R / L
- ☐ Knee R / L ☐ Tib-fib R / L
- ☐ Ankle R / L ☐ Foot R / L
- ☐ Toe R / L
- ☐ Shoulder R / L ☐ Humerus R / L
- ☐ Elbow R / L ☐ Forearm R / L
- ☐ Wrist R / L ☐ Hand R / L
- ☐ Finger R / L ☐ Ribs R / L
- ☐ Clavicle R / L ☐ Scoliosis
- ☐ Skull Series ☐ Bone Age
- ☐ Metastatic Series

INTERVENTIONAL

- ☐ Paracentesis
- ☐ Repeat Paracentesis PRN
- ☐ Thoracentesis
- ☐ Biopsy (specify):
  - ☐ Lung Bx ☐ Breast Bx
  - ☐ Thyroid Bx
- ☐ Breast Cyst Aspiration w/ US

ULTRASOUND

- ☐ Right Upper Quadrant / Gall Bladder
- ☐ Renal ☐ Liver
- ☐ Aorta ☐ OB
- ☐ Abdomen Complete
- ☐ Pelvic with Endovaginal
- ☐ Breast US
- ☐ Breast US w/ Bx as needed
- ☐ Testicular / Scrotal
- ☐ Carotid
- ☐ Venous Doppler - Upper Extremity
  - ☐ Bil ☐ Rt. ☐ Lt.
- ☐ Venous Doppler - Lower Extremity
  - ☐ Bil ☐ Rt. ☐ Lt.
- ☐ Lower Extremity, Arterial Vascular / Duplex
- ☐ Upper Extremity, Arterial, Vascular / Duplex
- ☐ Hip (infant) ☐ Spine (infant)
- ☐ Thyroid

MAMMOGRAPHY / WOMEN'S IMAGING

- ☐ Screening Mammogram Bilateral
- ☐ Screening Mammogram Unilateral: R / L
- ☐ Diagnostic Mammo w/ US as needed
- ☐ Breast US
- ☐ Diagnostic Mammo w/ US & Bx as needed

OTHER

COMPUTED TOMOGRAPHY (CT)

EXAM	W/O	W	W/O+W
Head	☐		☐
Facial	☐	☐	
Sinus - Coronal Reconstruction	☐	☐	
Orbits	☐	☐	
Temporal Bone	☐	☐	
Soft Tissue Neck	☐	☐	☐
Chest	☐	☐	
Chest PE Protocol		☐	
Chest / Abdomen / Pelvis	☐	☐	
Neck / Chest / Abdomen / Pelvis	☐	☐	
Abdomen	☐	☐	
Abdomen / Pelvis	☐	☐	
Pelvis	☐	☐	
Cervical Spine	☐	☐	
Thoracic spine	☐	☐	
Lumbar Spine	☐	☐	
DEDICATED PROTOCOL			
Stone Protocol (Abdomen & Pelvis)	☐		
Renal Mass			☐
Chest PE		☐	
Pancreas			☐
Hematuria			☐
Multiphase Liver			☐
3D Reconstruction			
Extremity: R / L	☐	☐	
Coronary Calcium Score	☐		

☐ CT Angiography

☐ Head ☐ Chest ☐ Pelvis

☐ Neck ☐ Abdomen ☐ Aorto Femoral Run-off

Other:

REV. 7/08

PHYSICIAN SIGNATURE

Notification to Physicians and Other Persons Legally Authorized to Order Tests for Which Medicare Reimbursement Will Be Sought. Medicare will pay only for tests that meet the medicare coverage criteria and are reasonable and necessary to treat or diagnose an individual patient. Medicare does not pay for tests for which documentation, including the patient record, does not support that the tests were reasonable and necessary. Medicare generally does not cover routine screening tests even if the physician or other authorized test ordered considers the tests appropriate for the patient.