

# DIAGNOSTIC IMAGING ORDER FORM

Please type into this form for expedited service

<input type="checkbox"/> <b>OAKLAND</b> 747 52nd St., #210, Oakland, CA 94609 Hours: Mon-Fri 7am-8pm; Sat/Sun 7am-3pm Phone: (510) 428-3410 Non-Urgent Fax: (510) 985-2202 Urgent Fax: (510) 450-5837	<input type="checkbox"/> <b>WALNUT CREEK</b> 2401 Shadelands Dr, 180B, Walnut Creek, CA 94598 Hours: Mon-Sat 8am-4pm (most modalities) Phone: (925) 979-3410 Non-Urgent FAX: (510) 985-2202 Urgent Fax: (925) 979-3404	The Interpreting Radiologist will determine the parameters of the diagnostic X-ray based on the patient's symptoms and department protocols and will change the order as necessary. <b>Check this box if you would like to be notified prior to a change.</b> <input type="checkbox"/>
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## SECTION A: THE INFORMATION BELOW IS REQUIRED

Patient's First Name _____ Last Name _____	Referring MD _____
DOB ____/____/____ Phone Contact # (____) _____	MD Signature _____ Date ____/____/____
Mail Address _____	MD Phone(____) _____ Pager(____) _____
Parent/Guarantor First Name _____	MD Fax(____) _____
Parent/Guarantor Last Name _____ DOB ____/____/____	<b>SPECIAL INSTRUCTIONS</b> _____
Insurance _____ Auth # _____	
Group # _____ Member ID # _____	
<b>PREFERRED DAY/TIME:</b> _____	<b>ICD-10 CODE # and Description:</b> _____
<b>PATIENT HISTORY</b> Include signs, symptoms, and/or known diagnoses, <b>NO R/O</b>	
	<input type="checkbox"/> No <input type="checkbox"/> Yes
	<b>IF NEW PATIENT, PLEASE SEND DEMOGRAPHICS OR FACE SHEET</b>

## SECTION B: PLEASE SELECT FROM THE FOLLOWING OPTIONS

<input type="checkbox"/> <b>GENERAL DIAGNOSTIC X-RAY PLAIN FILM</b>				
Finger <input type="checkbox"/> Lt <input type="checkbox"/> Rt Hand <input type="checkbox"/> Lt <input type="checkbox"/> Rt Wrist <input type="checkbox"/> Lt <input type="checkbox"/> Rt Forearm <input type="checkbox"/> Lt <input type="checkbox"/> Rt Elbow <input type="checkbox"/> Lt <input type="checkbox"/> Rt Humerus <input type="checkbox"/> Lt <input type="checkbox"/> Rt Shoulder <input type="checkbox"/> Lt <input type="checkbox"/> Rt Clavicle <input type="checkbox"/> Lt <input type="checkbox"/> Rt <input type="checkbox"/> Bone Age (PA Left Hand/Wrist)	Toes <input type="checkbox"/> Lt <input type="checkbox"/> Rt Foot <input type="checkbox"/> Lt <input type="checkbox"/> Rt Heel Calcaneus <input type="checkbox"/> Lt <input type="checkbox"/> Rt Ankle <input type="checkbox"/> Lt <input type="checkbox"/> Rt Tib/Fib <input type="checkbox"/> Lt <input type="checkbox"/> Rt Knee <input type="checkbox"/> Lt <input type="checkbox"/> Rt Femur <input type="checkbox"/> Lt <input type="checkbox"/> Rt Pelvis <input type="checkbox"/> AP <input type="checkbox"/> Lat Pelvis (CP surveillance) <input type="checkbox"/> AP <input type="checkbox"/> Lat Hip <input type="checkbox"/> Lt <input type="checkbox"/> Rt Leg Length <input type="checkbox"/> Lt <input type="checkbox"/> Rt	<input type="checkbox"/> Abd 1 view <input type="checkbox"/> Abd w/decub <input type="checkbox"/> Chest 1 view <input type="checkbox"/> Chest 2 view <input type="checkbox"/> Chest w/decub <input type="checkbox"/> Ribs <input type="checkbox"/> Rickets Survey <input type="checkbox"/> Skeletal Survey (dysplasia) <input type="checkbox"/> Skeletal Survey (NAT)	<input type="checkbox"/> C Spine AP/LAT <input type="checkbox"/> C Spine Lat Only <input type="checkbox"/> C Spine 3 view <input type="checkbox"/> C Spine w/Flex-Ext <input type="checkbox"/> Scoliosis PA Only <input type="checkbox"/> Scoliosis PA/Lat <input type="checkbox"/> Neck Soft Tissue AP/Lat <input type="checkbox"/> Neck Soft Tissue Lateral Only <input type="checkbox"/> L Spine AP/Lat <input type="checkbox"/> L Spine Complete w/obliques <input type="checkbox"/> T Spine AP/Lat	<input type="checkbox"/> Skull 2 views <input type="checkbox"/> Skull 3 views <input type="checkbox"/> Facial Bones <input type="checkbox"/> Nasal Bones <input type="checkbox"/> Sinus Series <input type="checkbox"/> Mandible <input type="checkbox"/> Special View Special View Detail:
<input type="checkbox"/> <b>MRI</b>	<input type="checkbox"/> <b>ULTRASOUND</b>	<input type="checkbox"/> <b>FLUOROSCOPY</b>	<input type="checkbox"/> <b>NUCLEAR MEDICINE</b>	<input type="checkbox"/> <b>CT</b>
General Anesthesia <input type="checkbox"/> N <input type="checkbox"/> Y IV Contrast <input type="checkbox"/> w/o <input type="checkbox"/> w MRA <input type="checkbox"/> MRV <input type="checkbox"/> <input type="checkbox"/> Brain <input type="checkbox"/> Brain Limited (Quick Scan) <input type="checkbox"/> C-Spine <input type="checkbox"/> T-Spine <input type="checkbox"/> L-Spine <input type="checkbox"/> Total Spine <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Abdomen MRCP <input type="checkbox"/> Abdomen MR Elastography <input type="checkbox"/> Pelvis <input type="checkbox"/> Wrist <input type="checkbox"/> Lt <input type="checkbox"/> Rt <input type="checkbox"/> Elbow <input type="checkbox"/> Lt <input type="checkbox"/> Rt <input type="checkbox"/> Shoulder <input type="checkbox"/> Lt <input type="checkbox"/> Rt <input type="checkbox"/> Knee <input type="checkbox"/> Lt <input type="checkbox"/> Rt <input type="checkbox"/> Ankle <input type="checkbox"/> Lt <input type="checkbox"/> Rt <input type="checkbox"/> Upper Extremity <input type="checkbox"/> Lt <input type="checkbox"/> Rt <input type="checkbox"/> Lower Extremity <input type="checkbox"/> Lt <input type="checkbox"/> Rt	Doppler <input type="checkbox"/> <input type="checkbox"/> Abdomen Complete <input type="checkbox"/> Abdomen Limited <input type="checkbox"/> w/contrast (liver lesion) <input type="checkbox"/> Chest <input type="checkbox"/> Hips Limited (effusion) <input type="checkbox"/> Neck <input type="checkbox"/> Infant Brain <input type="checkbox"/> Infant Hips <input type="checkbox"/> With Stress <input type="checkbox"/> Infant Spine <input type="checkbox"/> Renal (includes bladder) <input type="checkbox"/> Scrotum <input type="checkbox"/> Pelvic <input type="checkbox"/> Thyroid <input type="checkbox"/> Voiding Urosonography <input type="checkbox"/> Venous Doppler Specify Extremity:  <input type="checkbox"/> General Soft Tissue Specify Body Part:	<b>OAKLAND ONLY</b> <input type="checkbox"/> UGI <input type="checkbox"/> UGI w/SBFT <input type="checkbox"/> Esophagram <input type="checkbox"/> Contrast Enema <input type="checkbox"/> VCUG <input type="checkbox"/> Central Line Study <input type="checkbox"/> Fluoro Nonspecific <input type="checkbox"/> SBFT	<b>OAKLAND ONLY</b> General anesthesia <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> DMSA <input type="checkbox"/> Gallium Scan <input type="checkbox"/> Gastric Emptying <input type="checkbox"/> GFR <input type="checkbox"/> GI Bleed / tagged RBC <input type="checkbox"/> HIDA Scan <input type="checkbox"/> Mag 3 <input type="checkbox"/> Lung Perfusion Scan <input type="checkbox"/> Liver/Spleen Scan <input type="checkbox"/> Meckel's Scan <input type="checkbox"/> RNC <input type="checkbox"/> Bone Scan Whole Body <input type="checkbox"/> Bone Scan Limited <input type="checkbox"/> MIBG	<b>OAKLAND ONLY</b> General anesthesia <input type="checkbox"/> N <input type="checkbox"/> Y IV Contrast <input type="checkbox"/> w/o <input type="checkbox"/> w 3D <input type="checkbox"/> CTA <input type="checkbox"/> <input type="checkbox"/> Head <input type="checkbox"/> Maxillofacial <input type="checkbox"/> Sinus <input type="checkbox"/> Orbits <input type="checkbox"/> Temporal Bones/IAC's <input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Enterography <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Scanogram <input type="checkbox"/> Upper Extremity <input type="checkbox"/> Lt <input type="checkbox"/> Rt <input type="checkbox"/> Lower Extremity <input type="checkbox"/> Lt <input type="checkbox"/> Rt

OTHER PROCEDURES NOT LISTED ABOVE

**DIAGNOSTIC IMAGING POLICY: MUST HAVE COMPLETE ORDER AND DEMOGRAPHICS/REQUEST FORM TO SCHEDULE DIAGNOSTIC IMAGING EXAMS. NO AUTH = NO TEST & NO ICD-10 CODE = NO TEST**