

**OUTPATIENT ORDER
IMAGING SERVICES**
PLACE LABEL HERE
Imaging Scheduling:

 Phone: 678-312-3444
 Fax: 678-442-9736
 Precertification: 678-312-4095

 GHS to Schedule Patient? Yes No
 Patient already scheduled? Yes No
 Appointment Date: _____

Name: _____

DOB: _____

Location of Scheduled Appointment:

-
- Gwinnett Medical Center – Lawrenceville
-
-
- Gwinnett Women's Pavilion
-
-
- 575 Outpatient Imaging Center
-
-
- Gwinnett Medical Center – Duluth
-
-
- Outpatient Center at GMC – Duluth
-
-
- GMC Imaging Center – Hamilton Mill

Arrival Time: _____

Exam Time: _____

 Medicare? Yes No

 GMC to Precert Patient? Yes No

***If yes, copy of insurance card & clinical
documentation must be sent with order***

Precertification #: _____

Phone#1: _____

Phone#2: _____

Language: _____

**PATIENT MUST BRING THIS ORDER ON THE
DATE OF SERVICE.**

Allergies: _____

**ALL FLUOROSCOPY & ULTRASOUND
PROCEDURES MUST BE SCHEDULED.**

Symptoms/Diagnosis (with ICD-9 codes): _____

IMAGING WILL EVALUATE CREATININE LEVEL PRIOR TO TEST UNLESS LEVEL PERFORMED WITHIN 7 DAYS. RESULT: _____

SKULL & FACE	CHEST	ABDOMEN & GI TRACT	ULTRASOUND
--------------	-------	--------------------	------------

-
- Skull Series
-
-
- Facial Bones
-
-
- Orbits:
-
-
- Rt
-
- Lt
-
-
- Nasal Bones
-
-
- Sinus Series:
-
-
- Full Series
-
- Limited
-
-
- Other: _____

-
- Chest:
-
-
- PA & Lateral
-
-
- Decubitus:
-
-
- Rt
-
- Lt
-
- Bilateral
-
-
- Ribs:
-
-
- Rt
-
- Lt
-
- Bilateral
-
-
- Sternum
-
-
- Other: _____

-
- Acute Abdominal Series
-
-
- Barium Enema:
-
-
- Single
-
- Air Contrast
-
-
- Barium Swallow
-
- (esophagus)
-
-
- KUB
-
-
- Small Bowel Series
-
-
- Upper GI Series
-
-
- Other: _____

-
- Abdomen Complete
-
-
- Abdomen Limited
-
- Specify site: _____
-
-
- Kidneys
-
-
- Paracentesis:
-
-
- Pelvic OB (with transvaginal,
-
- if needed)
-
-
- Pelvic Non-OB (transvaginal
-
- & transabdominal)
-
-
- Transvaginal ONLY
-
-
- Transabdominal ONLY
-
-
- Retroperitoneum (AA, IVC)

SPINE & PELVIS	EXTREMITIES	OTHER PROCEDURES
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-
- Cervical Spine
-
-
- Thoracic Spine
-
-
- Lumbar Spine
-
-
- Pelvis
-
-
- Sacroiliac Joint
-
-
- Hip:
-
-
- Rt
-
- Lt
-
- Bilateral
-
-
- Sacrum and/or Coccyx
-
- specify: _____
-
-
- Scoliosis Series
-
-
- Other: _____

-
- Rt
-
- Lt
-
- Bilateral
-
-
- Specify site: _____
-
-
- Bone Length Scanogram
-
-
- Standing / Weight-Bearing
-
-
- Bone Age
-
-
- Other: _____

GU TRACT

-
- Cystogram:
-
-
- Static
-
- Voiding
-
-
- IV Pyelogram with Post Void
-
-
- Other: _____

-
- Arthrogram: (with Contrast)
-
- Specify: _____
-
-
- Rt
-
- Lt
-
-
- with MRI
-
-
- with CT
-
-
- Hip Injection:
-
-
- Rt
-
- Lt
-
-
- Hysterosalpingogram
-
-
- Myelogram with CT to follow:
-
-
- Cervical
-
-
- Thoracic
-
- Specify level: _____
-
-
- Lumbar
-
-
- Other: _____

-
- Testicular
-
-
- Thoracentesis:
-
-
- Rt
-
- Lt
-
-
- Thyroid
-
-
- Thyroid Biopsy:
-
-
- Rt
-
- Lt
-
- Bilateral
-
-
- Venous Upper Extremity:
-
-
- Rt
-
- Lt
-
- Bilateral
-
-
- Venous Lower Extremity:
-
-
- Rt
-
- Lt
-
- Bilateral
-
-
- Other: _____

 Physician Name (print): _____ STAT Results to: Phone Fax: _____
 Physician Signature: _____ Hold patient and Call Physician's cell: _____
 Physician NPI#: _____ Date: _____ CC report to: _____

Tests should only be ordered that are medically necessary for the diagnosis, symptoms, and /or treatment. The patient may be billed for tests that are NOT deemed necessary by payors. Please submit all (appropriate) clinical indications for all test (s) ordered. The procedure will NOT be performed in the absence of the completed form including the appropriate diagnosis and/or ICD-9 codes supporting the ordered procedure. Ordering physicians are responsible for the accuracy of the information provided.

