Advanced
MEDICAL IMAGING

DIAGNOSTIC ORDER FORM

PLEASE BRING THIS LEGAL DOCUMENT TO YOUR APPOINTMENT

PLEASE PRINT

Patient Legal Name:_____ **Date of Birth:**_____
Last First MI MM DD YY

Social Security #:_____ **Primary Cardholder's Name:**_____

Insurance Company:_____ **Policy #:** _____

Date **Arrival Time** **Test Time** **Patient Instruction** ___ NPO after midnight ___ No Prep ___ P/U prep kit or oral contrast ___ Other	**Procedure Name:** **Medical Necessity: (Signs & Symptoms)** **Special Instructions:** ____ Nuclear Medicine Bone Scan: Perform additional plain films, if necessary	Check only ONE if applicable: ___ Contrast per Radiologist discretion ___ No IV Contrast ___ With IV Contrast ___ With and without IV Contrast BUN_____result Creatinine_____result Date Drawn____/____/____ Lab work drawn at: _____ ___ To be drawn at facility prior to test *Need within 30 days prior to procedure
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Date **Arrival Time** **Test Time**	**MAMMOGRAPHY** **Screening Mammogram** ___ Bilateral ___ Right ___ Left **Baseline Mammogram** ___ Bilateral ___ Right ___ Left **Diagnostic Mammogram** ___ Bilateral ___ Right ___ Left	IMPLANTS? _____Yes _____No Check if applicable: ___ Perform/schedule ultrasound if mass or density present ___ Perform/schedule aspiration if cystic mass present ___ Perform/schedule biopsy, if indicated

Physician/PA/APRN Signature: _____ Date: _____

Name of Sponsoring Physician: _____ Report copy to: _____

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