

Sample Outpatient Radiology Order Form for ordering

PET-MR at the BRIC

UNC Health Care System		MIM #1169			
101 Manning Drive, Chapel Hill, NC 27514					
Outpatient Radiology Order Form					
Clinic Name/Clinic Code: _____					
Ordering Provider Name: _____					
Ordering Provider Code: _____			Provider Pager: _____		
Clinic Contact: _____			Pager/tel no.: _____		
Date of Service		Time of Service		Addressograph	
Procedure	Body Part/Procedure	CPT Code(s)	ICD-9 Code(s)	Witt	
CT fax:(919)843-0924					
MRI fax:(919)966-8046					
PET fax:(919)843-0924	Include PET-MR at the BRIC along with the desired body part				
Nuclear Medicine fax:(919)843-0924					
Diagnostic X-RAY/QDR fax:(919)843-2900					
Ultrasound fax:(919)843-0924					
Fluoroscopy fax:(919)843-2900					

Steps for ordering Pet/MR:

1. Call Radiology Scheduling at (919) 843-6509 or (919) 966 1884.
2. Fax completed order form to (919) 843-0924. Completed form must include:
 - 2 patient identifiers: full name and medical record number and/or birthday
 - the date of the order
 - the name of the physician ordering plus signature of that physician, with the date & time of the signature
 - the type of test, diagnosis (ICD-9) and CPT used at the time of scheduling

Frequently Used CPT Codes:

Pet/MR Skull to Thigh 78812
-Pet/MR Whole Body 78813
-Pet/MR Brain 78608

1. Please provide the most relevant signs and/or symptoms: _____

2. What is suspected or being ruled out? _____

3. Diagnosis: _____ Suspected? _____ or Confirmed? _____

CT Scan Scheduling Questions: If yes to any of the answers please inform Radiology scheduler.

YES NO 1. Has the patient had an allergic reaction to IV contrast?

YES NO 2. Is the patient on any medication containing metformin? (Glucophage)

YES NO 3. Does the patient have a history of diabetes, renal disease, multiple myeloma, lupus or scleroderma?

YES NO 4. Is the patient on IV antibiotics?

YES NO 5. Is the patient taking daily doses of NSAIDs (Advil, Aleve, Celebrex, Lodine, etc)?

YES NO 6. Does the patient have a recent (within 3 months) serum creatinine value? If yes, when?

YES NO 7. Pregnancy? _____ Date of LMP: _____

YES NO 8. Is patient currently on any blood thinners (e.g. Coumadin, Aspirin, Plavix, Effient)? If YES, most recent INR (1 week) _____

MRI Scheduling Questions: If yes to any of the answers please inform Radiology scheduler.

YES NO 1. Does this patient have a cardiac pacemaker?

YES NO 2. Does this patient have an aneurysm clip?

YES NO 3. Does the patient have an artificial cardiac heart valve?

YES NO 4. Does the patient have any mechanical devices or implants (neurostimulators, cochlear, etc.)?

Medicare will only pay for services that it determines to be reasonable and necessary under section 1862 (a)(1) of the Medicare Law. When ordering tests for which Medicare reimbursement will be sought, physicians should order only those individual tests that are necessary for the diagnosis and treatment of a patient, rather than for screening purposes.

Ordering Provider Signature: I certify that these diagnosis codes support the test ordered and the test(s) are medically necessary.

Signature: _____ Date: _____ Time: _____ Attending (if different) _____

Chart Location: Provider Orders