Division of Cleveland Clinic eRadiology
1855 Powder Mill Road
York, PA 17402
Phone: 717-747-8304 *(8 a.m. to 5 p.m.)*
Fax: 717-741-9426

APPOINTMENT TIME: _____
(Please arrive 30 min. prior to the appt. time)

APPOINTMENT DATE: _____
Please complete form and fax to our office at 717-741-9426. Thank you!

IMAGING ORDER FORM

Patient Name: _____ Birth date: _____ Phone: _____ M F

Referring physician: _____ Physician phone: _____ Physician fax: _____

Insurance Company: _____ ID#: _____ Group #: _____

Pre-Authorization #: _____ Dates Valid: _____

Evaluate/Rule Out: _____

Body Site: _____ □ RIGHT □ LEFT

History/Symptoms: _____ ICD-10 Dx Code: _____
(required)

Physician Signature*:** _____ ***Date*:** _____ ***NPI: _____

Check if Medically Necessary: □ **With Contrast** □ **Orbits** □ **Creatinine**

MRI

□ **W/O Contrast**
□ **W & W/O Contrast**

HEAD & NECK
□ MR Brain/Head
□ MR Brain w/ IAC
□ Soft Tissue Neck

BODY / TRUNK
□ MR Abdomen
□ MR Pelvis
□ MR Abd/Pelvis
□ MRCP
□ Chest

SPINE
□ MR Cervical Spine
□ MR Thoracic Spine
□ MR Lumbar Spine

JOINT(S)
□ Upper □ Lower
□ RT □ LT
□ Arthrogram
Body Part: _____

NON-JOINT(S)
□ Upper □ Lower
□ RT □ LT
Body Part: _____

CT

□ **W/O Contrast**
□ **W/Contrast**
□ **W & W/O Contrast**

HEAD & NECK
□ CT Brain □ CT Orbits
□ CT Sinus □ CT Maxillofacial
□ CT Neck, Soft Tissue
□ IAC
□ Temporal Bones

BODY / TRUNK
□ CT Chest
□ CT Abdomen/Pelvis
□ CT Abdomen Only
□ CT Pelvis Only
□ CT Renal Stone (Abd/pelvis)

SPINE
□ CT Cervical Spine
□ CT Thoracic Spine
□ CT Lumbar Spine

ANGIOGRAPHY (CTA)
NOTE: IV CONTRAST
□ CT Chest
□ CT Pulmonary
□ CT Abdomen
□ CT Abdomen/Pelvis
□ CT Carotids
□ CT Aorta-iliofemoral w/runoff
□ CT Lower Extremity
□ CT Upper Extremity
□ CT Head

EXTREMITY
RT LT ***(circle one)***
□ CT Upper Extremity
Body Part _____
□ Arthrogram

□ CT Lower Extremity
Body Part _____
□ Arthrogram

ULTRASOUND

GENERAL
□ **US Abdomen Complete**
□ **US Abdomen Limited**
□ **RUQ/LIVER/GB/PAN**
□ **LUQ/SPLEEN/LT/KID**

□ **Renal/Bladder**
□ **With post void**

□ **Scrotum/Testicles**

□ **Soft Tissue**
Site_____

□ **Thyroid**

□ **OTHER – SPECIFY**
_____

VASCULAR
□ **Venous**
□ **Upper** □ **Lower**
□ **Bilateral** □ **Unilateral**
RT LT ***(circle one)***
□ **Carotid**
□ **Aorta-Iliacs-for AAA**
□ **AAA Medicare Screen**
□ **PAD Screen (Peripheral Arterial Disease-Self pay $103)**

NON-VASCULAR
□ **Bilateral** □ **Unilateral** __
Body Part: _____
RT LT ***(circle one)***

X-RAY

□ Skull
□ Orbits
□ Facial Bones
□ Sinuses
□ Chest Pa/Lateral
□ Sternum
□ Ribs ..... R L B
□ Clavicle ..... R L B
□ Shoulder ..... R L B
□ Humerus ..... R L B
□ Elbow ..... R L B
□ Forearm ..... R L B
□ Wrist ..... R L B
□ Hand ..... R L B
□ Finger Digit..... R L B
□ Cervical Spine
□ Thoracic Spine
□ Lumbar Spine w/Obl
□ Pelvis
□ Hip ..... R L B
□ Femur ..... R L B
□ Knee ..... R L B
□ Tibia/Fibia..... R L B
□ Ankle ..... R L B
□ Foot ..... R L B
□ Scoliosis Series
□ Abdomen Flat Plate (Kub)
□ Other:
_____

□ **DEXA SCAN**
Date of last Dexa exam
_____
□ Body Comp-Initial $150
□ Body Comp-Follow Up $100
(both exams Self Pay)