Providence

DIAGNOSTIC IMAGING
Kodiak Island Medical Center

Phone: 907-486-9520
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TODAY'S DATE

PATIENT LEGAL NAME	DATE OF BIRTH	PATIENT PHONE
INSURANCE NAME	MEMBER/ POLICY/ ID#	PRE-AUTHORIZATION #
PROVIDER NAME	PROVIDER SIGNATURE DATE TIME	PROVIDER TELEPHONE
CPT CODE	ICD 10	
DECISION SUPPORT / VENDOR (G CODE)	ADHERENCE CODE (M MODIFIER) / ID	SCORE
REASON FOR EXAM		

Direct Provider Contact Number (pager, cell, etc.): _____ Provider Fax Number: _____

❑ Report and CD ❑ Routine ❑ Urgent
❑ Patient return to clinic

MRI
❑ Without Contrast
❑ Contrast at Radiologist Discretion
❑ With and Without Contrast
❑ Brain ❑ Lumbar Spine
❑ MRA Brain ❑ Abdomen
❑ MRA Neck ❑ MRA Abdomen
❑ Soft Tissue Neck ❑ Pelvis
❑ Cervical Spine ❑ MRCP
❑ Thoracic Spine
❑ Shoulder L R
❑ Elbow L R
❑ Wrist L R
❑ Upper Extremity Non-Joint (specify)
_____
❑ Hip L R
❑ Knee L R
❑ Ankle L R
❑ Arthrogram _____ L R
❑ Lower Extremity Non-Joint (specify)
_____
❑ Other (specify) _____

CT
❑ Without Contrast
❑ Contrast at Radiologist Discretion
❑ With and Without Contrast
❑ Brain ❑ Chest ❑ IAC's
❑ Sinus ❑ Abdomen
❑ Soft Tissue Neck ❑ Pelvis
❑ Cervical Spine ❑ Abdomen/Pelvis
❑ Thoracic Spine ❑ Chest/Abdomen/Pelvis
❑ Lumbar Spine ❑ Add 3D Images
❑ Urogram ❑ Chest PE
❑ Renal Stone ❑ IVP
❑ Angio_____
❑ Other (specify) _____

Bone Densitometry (DEXA)
❑ DEXA Routine Screening

Additional Comments
_____
_____
_____
_____
_____

Radiology
❑ Cystogram
❑ Esophagram
❑ VCUG ❑ Barium Swallow
❑ Upper G.I.
❑ Video Swallow
(Speech Therapy)
❑ Small Bowel Follow Through
❑ Barium Enema ❑ HSG
❑ Chest X-Ray (PA/lateral)
❑ Ribs L R
❑ Shoulder L R
❑ Humerus L R
❑ Elbow L R
❑ Forearm L R
❑ Wrist L R
❑ Hand L R
❑ Finger L R
❑ Cervical Spine
❑ Thoracic Spine
❑ Lumbar Spine
❑ Abdomen Supine
❑ Abdomen Supine & Upright
❑ Pelvis
❑ Femur L R
❑ Hip (includes pelvis) L R
❑ Knee L R
❑ Tibia/Fibula L R
❑ Ankle L R
❑ Foot L R
❑ Toe L R
❑ Other (specify) _____

Ultrasound Vascular
❑ Carotid
❑ Venous L R
❑ Arterial L R
❑ Upper Ext. L R
❑ Lower Ext. L R
❑ ABI's
❑ Arterial Leg L R
❑ Abdominal
❑ Mesenteric
❑ Portal Vein
❑ Renal Artery ❑ Transplant
❑ Nonvascular Limited
❑ Pseudoaneurysm Location
_____

Breast Imaging
❑ Screening Mammogram (no signs or symptoms)
❑ Diagnostic Mammogram L R
❑ Ultrasound if indicated
❑ Breast Ultrasound L R
❑ Diagnostic Mammogram if indicated
❑ Axilla ❑ Palpable ❑ Follow-up L R
❑ Biopsy L R
❑ Ultrasound
❑ Cyst Aspiration L R
❑ Other_____
❑ ***Additional breast imaging indicated by the radiologist, including biopsy.***

Indications
_____
_____
_____
_____

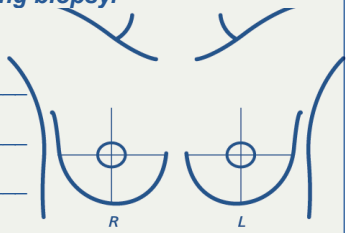

Diagram must be completed for all signs/symptoms

Ultrasound
❑ Soft Tissue Neck
Specify location: _____
❑ Abdomen
❑ Complete ❑ Limited ❑ RUQ ❑ LUQ
❑ Renal
❑ Complete ❑ Limited
❑ Renal Transplant
❑ Pyloric
❑ Bladder (pre and post void)
❑ Aorta screening
❑ Pelvis with Transvaginal
❑ Pelvis without Transvaginal
❑ OB: ❑ > 14 weeks ❑ < 14 weeks ❑ w/Transvaginal
❑ OB: Limited/follow up ❑ w/Transvaginal
❑ OB BPP non-stress
❑ OB Intracranial MCA doppler
❑ Follicular Study ❑ Transvaginal
❑ Include Transabdominal
❑ Scrotal ❑ Echocardiogram
❑ Thyroid ❑ Lymph node mapping
❑ Umbilical Doplar ❑ OB Dating_____
❑ Transabdominal ❑ Transvaginal if Needed
if Needed
❑ Limited (hernia)
❑ Appendix
❑ Cervix Length
❑ Other (specify) _____