This form is part of the patient's medical record and must be completed for referral

2012

Date of Referral____-____-____ Referring Provider Name_____

Patient Name (first, MI, last)_____

Patient Phone # (_____) _____-_____(home) (_____) _____-_____(work or cell)

D.O.B. _____-_____-_____ SS# _____-_____-_____ ☐ Translator? _____ (Language)

Written Diagnosis/Reason/Symptom for Exam(s) *REQUIRED*

Medicare and other insurers require coding of specific/definitive diagnosis(es), sign(s) or symptom(s) to reflect the "medical necessity" for each test.
Rule out, Possible or Probable Conditions cannot be coded. For Medicare Policy information see the Part B Bulletin or www.noridian.com/medweb

Notes: Height_____ Weight_____

Allergies _____

☐ Physical Assistance Required

Breast cancer history Lt ____ Rt ____

Mastectomy history Lt ____ Rt ____

Implants? Y ____ N ____

PRIOR EXAMS:

_____ Date of Service _____ Facility Location

Other Last Name: _____

Breast Imaging & Bone Density

Screening Services

Mammography

☐ Screening Mammogram (no symptoms)

Bone Densitometry (DEXA)

☐ Spine & Femur

☐ **Other (Specify)**_____

Diagnostic Services

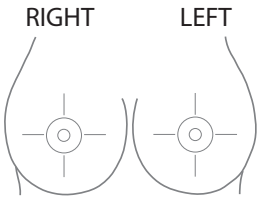
☐ Diagnostic Mammogram **lt rt bilat**
(Ultrasound if needed)
☐ Needle Biopsy if indicated

☐ Needle Loc **lt rt bilat**

☐ Stereotactic Breast Biopsy **lt rt bilat**

☐ Galactogram **lt rt bilat**

Indicate area of concern



Ultrasound

☐ Breast **lt rt bilat**

☐ Breast Cyst Aspiration **lt rt bilat**

☐ Guided Breast Biopsy **lt rt bilat**

MRI exam

Pacemaker: Y / N *(if YES, MRI services unavailable)*

Creatinine/GFR ____ / ____ (date drawn) ____ / ____ / ____

☐ Creatinine blood draw at radiologist's discretion

☐ Breast MRI bilat with contrast
Limited Chest MRI if indicated (radiologist's discretion)

☐ Breast MRI guided biopsy **lt rt bilat**

Appointments:

Exam _____

Day/Date:_____ _____-_____-_____

Check In Time _____ : _____

Appt. Time _____ : _____

Exam _____

Day/Date:_____ _____-_____-_____

Check In Time _____ : _____

Appt. Time _____ : _____

☐ Call patient to schedule

☐ Patient will call to schedule

☐ Return patient to the office with films

☐ Call STAT (_____)_____-_____

☐ Fax STAT (_____)_____-_____

☐ Fax Routine (_____)_____-_____

Send: ☐ CD ROM ☐ Films

Additional reports to: _____

PCP: _____

Name of insurance is required:

Insurance authorization #
(if needed):

Original Signature REQUIRED by Referring Provider
(Medicare B News Bulletin #256, 8/29/09) →

For Office Use Only

Diagnostic Imaging Phys Orders

920800

Radiology Order Form

THIS REFERRAL IS CONFIDENTIAL AND IS INTENDED SOLELY FOR THE USE OF THE MEDICAL PROVIDER NAMED ABOVE. IF YOU ARE NOT THE INTENDED RECIPIENT OR THE INTENDED RECIPIENT'S AGENT, AND HAVE RECEIVED THIS COMMUNICATION IN ERROR, NOTIFY SENDER IMMEDIATELY AND DESTROY THIS DOCUMENT.