

UNIVERSITY OF VIRGINIA HEALTH SYSTEM DEPARTMENT OF RADIOLOGY/UVA IMAGING CT IMAGING REQUEST FORM

PLACE LABEL HERE

Ordering Date _____

SS# _____

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

Please **Fax** to (434) 243-0307-UVA Imaging @ Fontaine or 243-6999-Hosp East
Schedule at (434) 243-0321-UVA Imaging @ Fontaine or 243-6888-Hosp East

Patient Name: _____ MR# _____

Pre/Post-op Y N Date of Surgery _____ Date of Test _____

DOB ____/____/____ Weight: _____ Phone # _____

Insurance Company & Plan	Pre Authorization Number	Attending MD/Pic #	Ordering MD/Pic #
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Referring Clinic/Office Where Report Should Be Sent	Phone Number of Contact Person Name	Box & Fax Number
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STUDY DESIRED (Circle Side if appropriate)

X	Study		X	Study
	CT Procedures			Cardiac CT (EP Lab/Pre-Ablation)
	CT Brain (3 D recon as medically necessary)			Cardiac or Coronary CT/CTA (All other Areas)
	CT Facial Bones/Orbits (3 D recon as medically necessary)			CT IVP (3 D recon as medically necessary)
	CT Temporal Bone (3 D recon as medically necessary)			CT Angio Head (3 D recon as medically necessary)
	CT Sinus (3 D recon as medically necessary)			CT Angio Neck (3 D recon as medically necessary)
	CT Soft Tissue Neck (3 D recon as medically necessary)			CT Angio Chest (3 D recon as medically necessary)
	CT Cervical Spine (3 D recon as medically necessary)			CT Angio Abdomen (3 D recon as medically necessary)
	CT Thoracic Spine (3 D recon as medically necessary)			CT Angio Pelvis (3 D recon as medically necessary)
	CT Lumbar Spine (3 D recon as medically necessary)			CT Angio Upper Extrem LT RT (3 D recon as medically necessary)
	CT Chest (3 D recon as medically necessary)			CT Angio Lower Extrem LT RT (3 D recon as medically necessary)
	CT Abdomen (3 D recon as medically necessary)			CT Angio Aorta Illeofem Runoff (3 D recon as medically necessary)
	CT Pelvis (3 D recon as medically necessary)			CT Upper Extrem LT RT (3 D recon as medically necessary)
	CT Virtual Colonoscopy (3 D recon as medically necessary)			CT Lower Extrem LT RT (3 D recon as medically necessary)

Any Exam Not Listed(Specify):

Unless Specified, IV contrast will be decided upon by the Radiologist

Clinical Indications for Exam (Mandatory):

ICD-9 Dx Code (Mandatory):

Protocol (Internal Use Only):

Physician Signature _____

Does Patient have an iodine allergy? _____ **CREATININE:** _____ **DATE:** _____

If patient is taking Glucophage or generic metformin please check next box;
 Patient will need a Creatinine level drawn 48 hours post contrast

Special considerations: Non-English speaking Sz disorder Pregnancy

Other: _____

Is Sedation required? Yes No (Pediatric/Claustrophobic patients may require sedation)

Please check here if you do not wish the Radiologist to determine medical necessity.



Updated 5-07

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