Patient Name:	DX and/or	DX and/or ICD-9 Code/Signs/Symptoms: A. B.						
DOB:	<i>A</i> .							
Insurance Co.	В.							
msurance co.								
				* DV 0 - 1 - 1 - 1 - 1				
				in DX Code box belo		ordered		
		When tests a	sts are complete, send patient:					
Ordering Physician's Signature	Date	Home		To Office	To Office wit	h Results		
		Send/Fax res	ults to	:	FAX#			
CT D>	X NUCLEAR	MEDICINE	DX	DIAGNOSTIC RA	DIOLOGY/FLU	OROSCOPY	D)	
Head	Thyroid Scan		П	Head				
Routine Per Radiology Protocol	Pulmonary	perfusion 🗖 ventilation	1	Skull				
Sinus Full Limited	Bone, whole body	•		Facial Bones			Г	
Facial Bones	Bone, limited location:			Orbits				
Orbits	Bone, 3-phase location:	Bone, 3-phase location:			Other			
Soft Tissue Neck	Renal			Abdomen, Ches	t			
Chest with Sagittal/Coronal reconstruction	Hepatobiliary Scan			PA/Lateral Chest				
Routine	Hepatobiliary with CCK (ejection)		PA Chest				
Limited	Cardiac Imaging-Stress Re	esting		Ribs	☐ Right	☐ Left		
High Resolution	Other:			AP Abdomen				
PE-Protocol				Flat & Upright Ab	domen			
Abdomen with Sagittal/Coronal reconstruction				KUB				
Routine Abdomen with Pelvis, if indicated	PET/C	Т	DX	Other:				
Abdomen and Pelvis	Brain			Spine/Pelvis				
Pelvis	Skull Base to Mid Thigh			Cervical w/obliqu	es (4 views)			
CT IVP	Whole Body		\sqcup	Thoracic Spine				
Kidney Stone Protocol			Ш	Lumbar Spine w/	obliques (4 view	rs)		
Appendix Protocol	ULTRASOU	IND	DX	Lumbar Spine w/	flexion			
Virtual Colonoscopy	Thyroid		\sqcup	Extension (2 view	rs)			
Spine with 3D reconstruction	Breast 🗆	I Right ☐ Left	<u></u>	Pelvis AP				
☐ Cervical ☐ Thoracic ☐ Lumbar	Abdomen	Limited	<u> </u>	Other:				
Extremity with 3D reconstruction	Aorta		⊥	Extremity, Uppe	r			
Location: R L	GB/Liver		<u> </u>	Shoulder	Right	☐ Left		
	Kidney		<u> </u>	Humerus	☐ Right	☐ Left		
CT Angio-location:	☐ Pelvis ☐	☐ Pelvis ☐ Non-obstetrical		Elbow	🗅 Right	☐ Left		
Other Location:	☐ Obstetrical ☐	☐ Obstetrical ☐ Transvaginal		Forearm	Right	☐ Left		
Heart Screening:	Testicular with Doppler		<u> </u>	Wrist	☐ Right	☐ Left		
	Extremity: Non Vascular		└	Hand	☐ Right	☐ Left		
MRI D	US guided biopsy site:		⊢ I	Other:			L	
X-Rays if indicated-Per Radiology Protocol	Vascular Ultrasound St	tudies	DX	Extremity, Lowe	r		L	
Pelvis	Carotid Doppler		<u></u>	Hip, 2 views	☐ Right	☐ Left		
Hips ☐ Right ☐ Left	Venous Doppler	I Right ☐ Left	\sqcup	Femur	🗅 Right	☐ Left		
Brain		I Upper ☐ Lower	<u> </u>	Knee	☐ Right	☐ Left		
Soft Tissue Neck	Artery		└ .	Tib/Fib	Right	☐ Left		
Shoulder	Renal Duplex		└	Ankle	☐ Right	☐ Left		
Brachial Plexus	Art/vein Duplex	Limited	<u> </u>	Foot	☐ Right	☐ Left		
Breast	ABI		⊢ I	Other:			_	
Abdomen - specify location	Other:			Gastro Intestina	<u> </u>		L	
Knee ☐ Right ☐ Left	Segmental pressures	I Up ☐ Down	∐ -	Barium Enema			\vdash	
Ankle ☐ Right ☐ Left	-		<u>└</u> ┃	Esophagus			_	
Foot	Medical Necessity Policy: When ordering			Upper GI				
MR Angio-location	tests for which Medicare or Medicaid			Small Bowel				
MR Arthrogram-location	Reimbursement will be sought, physician			Other:				
Extremity - Site	should only order tests medically necessary for			Special Studies				
Cervical Spine	the diagnosis and treat	tment of the patient.]_	Arthrogram, shou		☐ Left	\perp	
Thoracic Spine	-	TAT]_	Venogram, extren		☐ Left	\perp	
Lumbar Spine	_].	Steroid Injection-l	ocation		\vdash	
Other Location	Advance	d Diagnostic Imaging	- 1	Other:			1	

Radiology Exam Order Form

Date: _______ A.M. P.M.

Exam Time: ______ A.M. P.M.

Prep Instructions: ______

If you need to cancel your exam, please call in advance to (319) 234-3154 or Toll free (877) ADI-5345.

Bring this form and your insurance information with you to your appointment. Verify with your insurance company if you need preapproval.

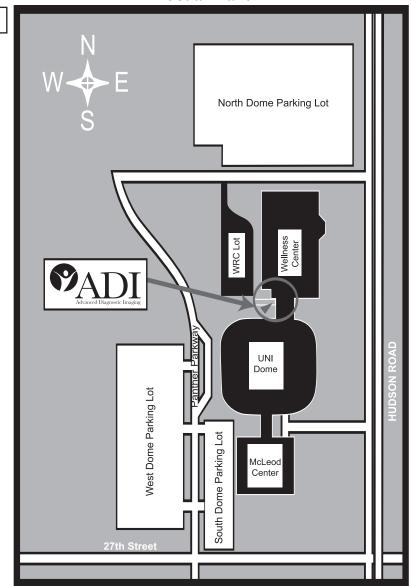
ADI Waterloo

Entrance A: MRI, CT, X-Ray, Nuclear Entrance B: Open MRI, Ultrasound, PET/CT



4006 Johnathan Street Waterloo, IA 50701 Phone (319) 236-2700 (877) 234-5345 FAX: (319) 236-2714

Cedar Falls



Waterloo

