SUTTER BUTTES
IMAGING
MEDICAL GROUP, INC.

REQUEST FOR DIAGNOSTIC IMAGING STUDY

945 Shasta Street, Yuba City, CA 95991 (530) 674-9000

Patient Name ______________________________ Date of Birth: ______________ Today's Date: ______________________

Referring DR: ______________________________ Phone: ____________________ Copy to DR: ______________

Reason for Exam (REQUIRED): ICD-9 Code: __________ or **HX:** ______________________________

STAT – PHONE REPORT ☐
Phone (**REQUIRED** for stat report):

NOTES AND/OR SPECIAL INSTRUCTIONS: ( ) ________ - __________

XRAY HEAD	CODE	
Nasal Bones-3 views	70160	
Neck for Soft Tissue	70360	
Sinuses - 3 views	70220	
Waters View	70210	52
Skull Series	70260	
XRAY CHEST		
Chest 1 view	71010	
Chest 2 view	71020	
Ribs-Left - 3 views	71101	
Ribs-Right - 3 views	71101	
Ribs-Bilateral-3 views	71111	
XRAY SPINE		
Cervical w/obliques	72050	
Thoracic	72072	
Lumbar w/obliques	72110	
Lumbar bending view	72114	
SI Joints	72200	
Scoliosis Study	72090	
Sacrum/Coccyx	72220	
XRAY PELVIS / HIPS		
Pelvis	72170	
Hip ☐ LT ☐ RT	73510	
Hips-Bilateral/Pelvis	73520	
UPPER EXTREMITIES ☐ L ☐ R		
Shoulder	73030	
Humerus	73060	
Elbow	73080	
Forearm	73090	
Wrist	73110	
Hand	73130	
Fingers	73140	
Arthrogram		
LOWER EXTREMITIES ☐ L ☐ R		
Femur	73550	
Knee	73564	
Tibia Fibula	73590	
Ankle	73610	
Foot	73630	
Os Calcis / Heel	73650	
Toes	73660	
Leg Lengths	76040	

ABDOMEN/KIDNEYS	CODE	
Abdomen 2V	74010	
KUB	74000	
IVP – ***may need labs***	74415	
G I TRACT		
Upper GI ☐ w or ☐ w/o air	7424_	
UGI w/small bowel	74245	
Small Bowel	74250	
BA Swallow	74220	
Barium Enema	74270	
B E with Air	74280	
ULTRASOUND		
Breast ☐ LT ☐ RT	76645	
Abdomen	76700	
Renal	76770	
Pelvic/Transvaginal	76856/76830	
Hysterosalpingogram		
Pregnant Uterus 14+weeks	76805	
Thyroid	76536	
Scrotal	76870	
Doppler ☐ Arterial ☐ Venous		
Carotid	93880	
Extremity ________________		
C T SCAN		
Head - w/o	70450	
Head - w & w/o	70470	
Chest/Thorax – W and/or W/O		
Abdomen – W and/or W/O		
Pelvis – W and/or W/O		
Abdomen/Pelvis W and/or WO		
Soft Tissue Neck	70491	
Urogram (SEE OVER FOR STUDY DETAILS)		
Cervical	72125	
Lumbar	72131	
Sinuses	70486	
Extremity ☐ LT ☐ RT Body Part ________________		
CTA Aortic w/runoffs	75635	
CTA Renals	74175	
CTA Carotids	70498	
CTA Head	70496	
Dual Phase Liver	74170	

MAMMOGRAM	CODE	
Screening	G0202	
Diagnostic	G0204	
Unilateral ☐ LT ☐ RT	G0206	
MRI		
Brain – w/o	70551	
Brain - w & w/o	70553	
Brain/Orbits	70553/70543	
Brain, Pituitary	70553 x2	
Brain, IACS	70553 x2	
C-Spine w/o	72141	
Soft Tissue Neck	70543	
Lumbar - w/o	72148	
Lumbar - w & w/o **SEE OVER**	72158	
T-Spine - w/o	72146	
T-Spine - w & w/o	72157	
Extremity JOINT: please specify ☐ LT ☐ RT Body Part ________________		
Extremity NON-joint: please specify ☐ LT ☐ RT Body Part ________________		
MRCP – w & w/o	74183	
Abdomen w & w/o	74183	
Pelvis w/o	72195	
Pelvis w & w/o	72197	
MRA - Angiogram		
MRI / Arthrogram ☐ LT ☐ RT Body Part ________________		
TMJ	70336	
If indicated: Plain film xray orbits r/o foreign body in eyes	70300	√
BONE DENSITY		
Bone Density - axial	76075	
Bone Density - appendicular	76076	
Bone Density – VFA	76077	√
OTHER EXAMS		

ADDITIONAL ORDERING DETAIL OVER, PLEASE

Scheduling (530) 674-9000   Fax Orders (530) 671-3535 or (530) 671-8591

☐ **URGENT – SPECIAL CIRCUMSTANCES** ☐ **AS SOON AS POSSIBLE – COMPLETE ON OR BEFORE:** ____________________

MRI

☐ Prior exam or plain films related to this study
When ______________
Facility ______________
☐ Pacemaker, TENS unit, Cochlear Implant – **MRI CONTRAINDICATED**
☐ Stent (<6 weeks **MRI MAY BE CONTRAINDICATED**)
Anatomical location ______________________
☐ HX of welding or sheetmetal work
☐ Prior lower back surgery – order contrast study
☐ Metal or foreign object to body – order plain films
☐ Claustrophobic
☐ Pt >300 lbs

CT

☐ Prior exam or plain films related to this study
When ______________
Facility ______________
☐ Allergic to iodine
☐ Renal disease/insufficiency – **labs required for contrast study**[1]
☐ Diabetic – **labs required for contrast study**[1]
☐ Pt >350 lbs
[1]Labs = BUN/Creatinine < 6 wks

UROGRAM

(*CT Abd w&w/o & CT Pelv w&w/o OR CT Abd w/o & CT Pelv w/o)

☐ Prior exam
When __________________
Facility __________________
☐ Hematuria
☐ Painful (non-contrast study)
☐ *No pain **(contrast study)**
☐ Allergic to iodine
☐ Diabetic – **labs required for contrast study**[1]
☐ Renal disease/insufficiency – **labs required for contrast study**[1]
☐ Hypertensive
☐ Pt >350 lbs
[1]Labs = BUN/Creatinine < 6 wks

MAMMOGRAM

☐ Baseline – no prior ☐ Routine – annual
☐ 6-mo follow-up
☐ Prior mammogram
When ________________
Facility________________
☐ Pt HX of breast CA
☐ Pain/swelling/discharge/palpable lump
☐ Prior surgery of any kind to breast and/or implants
☐ Breast size >D cup

ULTRASOUND

☐ Prior exam related to this study
When ________________
Facility ________________
☐ OB ☐ Twins
LMP ________________
☐ Breast = palpable lump AND pt <30

BONE DENSITY

☐ Prior exam
When ______________
Facility ______________
☐ Wheelchair bound

DIAGNOSTIC XRAY (KUB/IVP/SBFP/BE/UGI/BASW)

☐ Prior exam
When ____________________
Facility ____________________
☐ Allergic to iodine
☐ Renal/liver disease/insufficiency – **labs required for contrast study**[1]
☐ Diabetic – **labs required for contrast study**[1]
☐ Coumadin
☐ Glucophage
☐ Pt >300 lbs
[1]Labs = BUN/Creatinine < 6 wks

NOTES: ____

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ADDITIONAL ORDERING DETAIL OVER, PLEASE