



REQUEST FOR DIAGNOSTIC IMAGING STUDY

PLEASE PRINT LEGIBLY

945 Shasta Street, Suite 100 ■ Yuba City

*** REQUIRED FIELDS**

To Schedule an Appointment (530) 674-9000

*PATIENT NAME: _____ *DOB: _____ TODAY'S DATE: _____

*REFERRING DR: _____ PHONE: _____ COPY TO: _____
CHECK FOR STAT PHONE REPORT

*CHIEF COMPLAINT: _____ *HISTORY: _____

*SIGNS/SYMPTOMS _____ CLINICAL FINDINGS: _____

XRAY HEAD		CPT	ULTRASOUND		CPT	MRI		CPT
Nasal bone 3V		70160	Renal (4 hrs NPO)		76770	Brain WO		70551
Neck for soft tissue		70360	Abdomen (8 hrs NPO)		76700	Brain W&WO		70553
Sinuses		70220	Gallbladder (12 hrs NPO)			Brain/Orbits		70553/70543
Sinuses <3V		70210	Pelvic/transvaginal		76856/76830	Brain/Pituitary		70553
Skull series		70260	Thyroid		76536	Brain/IACS		70553
XRAY CHEST			Doppler ARTERIAL bilat 93925/93922			Cervical spine WO		
Chest 1 view		71045	Doppler VENOUS <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilat			Soft Tissue Neck, Face, Orbits		
Chest 2 vw		71046	Doppler CAROTID			Lumbar spine WO		
Ribs <input type="checkbox"/> L <input type="checkbox"/> R (+1v chest)		71101	Scrotal			Lumbar spine WWO (indicated only if hx of lumbar surgery)		
Ribs Bilateral (+1v chest)		71111	Extremity NON-Vascular			72158		
XRAY SPINE			body part _____			76882		
Cervical w/obliques		72050	Groin/inguinal			76881		
Cervical <4 views		72040	Soft Tissue Neck			76536		
Thoracic		72072	Other: _____			Extremity joint <input type="checkbox"/> L <input type="checkbox"/> R		
Lumbar w/obliques		72110	CT SCAN <input type="checkbox"/>W <input type="checkbox"/>WO			Body Part: _____		
Lumbar <4 views		72100	Head			MRI Arthrogram <input type="checkbox"/> L <input type="checkbox"/> R		
SI joints		72200	Soft tissue neck			body part: _____		
Scoliosis study		72082	Chest/Thorax			TMJ		
Sacrum/coccyx		72220	Abdomen/Pelvis			Abdomen W&WO		
XRAY PELVIS/HIPS			Renal			Pelvis WO		
Pelvis			Urogram (Abd/pelv WO)			74183		
Hip/pelvis <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral			(indicated for stones/pain)			Pelvis W&WO		
			Urogram (Abd/pelv WWO)			72195		
XRAY ABDOMEN			(indicated for painless hematuria)			72197		
Abdomen 2V & chest		74022	Multiphase:			MRI Angiogram		
KUB			<input type="checkbox"/> Kidney/pelvis (Abd/pelv WWO)			For MRI xray orbits to r/o foreign body in eyes if indicated by hx		
UPPER EXTREMITY <input type="checkbox"/>L <input type="checkbox"/>R			<input type="checkbox"/> Liver <input type="checkbox"/> Adrenal <input type="checkbox"/> Pancreas (Abd WWO)			70030 ✓		
<input type="checkbox"/> Finger <input type="checkbox"/> Hand <input type="checkbox"/> Wrist			Spine: <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar			SPECIAL PROCEDURES		
<input type="checkbox"/> Humerus <input type="checkbox"/> Forearm			Extremity <input type="checkbox"/> L <input type="checkbox"/> R Specify: _____			Arthrogram <input type="checkbox"/> L <input type="checkbox"/> R		
<input type="checkbox"/> Elbow <input type="checkbox"/> Shoulder <input type="checkbox"/> Clavicle			Sinus (maxillofacial) WO			body part: _____		
LOWER EXTREMITY <input type="checkbox"/>L <input type="checkbox"/>R			CTA <input type="checkbox"/> Head <input type="checkbox"/> Renal <input type="checkbox"/> Carotid			Kenalog shoulder <input type="checkbox"/> L <input type="checkbox"/> R		
<input type="checkbox"/> Femur <input type="checkbox"/> Knee <input type="checkbox"/> Tib-fib			CTA Aortic w/runoff			Vertebroplasty CONSULTATION 99202		
<input type="checkbox"/> Foot <input type="checkbox"/> Ankle <input type="checkbox"/> Toes			Other CT: _____			L spine T spine Level: _____		
NOTES:						Vertebroplasty PERCUTANEOUS		
						(performed at Rideout Memorial Hosp)		
						L spine T spine Level: _____		

EXAM PREPARATION

For all exams, please advise scheduler if patient has mobility limitations or if there may be any reason to allot extra time for the exam.

◆ *Please check with your insurance carrier to determine whether a pre-authorization or utilization review is required for your examination/procedure.* ◆

MRI

ANY CONTRAST EXAM

- BUN/Creatinine required: age 60+ **OR** diabetic **OR** renal insufficiency

ALL EXAMS

- No metal jewelry, no zippers/metal on clothing

ULTRASOUND

PELVIC EXAM/OB EXAM

- Consume 32 oz of water beginning 90 minutes prior to exam time. **Do not release the bladder.**

ABDOMEN EXAM

- **NO** food or liquid 8 hours prior to exam time

RENAL

- **NO** food 4 hours prior to exam time. **NO** liquid 4 hours prior to exam, *except* consume 24 oz of water beginning 90 minutes prior to exam time. **Do not release the bladder.**

CT

ANY CONTRAST EXAM

- **NO** solid food or dairy products 4 hours prior to exam time
- BUN/Creatinine required: age 65+ **OR** diabetic **OR** renal insufficiency

ABDOMEN AND/OR PELVIC EXAM

- **NO** solid food or dairy products 4 hours prior to exam time
- Consume 32 oz of water beginning 45 minutes prior to exam time

SINUS EXAM

- **NO** sinus sprays 48 hours prior to exam time

General Scheduling: (530) 674-9000



*Dedicated coordinators
are available to answer
your questions:*

CT (530) 645-5337, fax (530) 645-5370
MRI (530) 645-5322, fax (530) 645-5362
Ultrasound (530) 645-5341, fax (530) 645-5369
Medical Records (530) 645-5328, fax (530) 645-5375