OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

RADIOLOGY DEPARTMENT
Email orders to radiology.orders@ocsri.org
OR fax orders to 918-505-3260

RADIOLOGY ORDER FORM

Patient Name (Last): _____ (First): _____

Patient Address: _____

DOB: _____ SSN: _____ Phone (Home): _____ (Cell): _____

Ordering Physician: _____ Clinical History: _____

ICD10 Code: _____ Need by Date: _____

Allergies: _____ Diabetic: ☐ Y ☐ N Height: _____ Weight: _____

Please fax copy of insurance card and authorization with order.

OCSRI-NPI 1962876045

Insurance Company: _____ Policy ID #: _____

Authorization #: _____

* If Medicaid authorization applies to imaging services, authorization must include TC and 26 Modifiers.

☐ Report only to office ☐ CD with report only to office ☐ Patient to hand-carry films

☐ HOLD AND CALL REPORT Call Report #: _____ Fax Report #: _____

Patient Name: _____ DOB: _____

CT

HEAD/NECK

w	w/o	
☐	☐	Brain
☐	☐	Sinuses
☐	☐	Temporal Bones/IAC
☐	☐	Orbits
☐	☐	Facial Bones
☐	☐	Neck Soft Tissue

CHEST

w	w/o	
☐	☐	Chest
☐		CTA Chest for PE

SPINE

w	w/o	
☐	☐	Cervical Spine
☐	☐	Thoracic Spine
☐	☐	Lumbar Spine

ABD/PELVIS

w	w/o	
☐	☐	Abdomen & Pelvis
	☐	Renal Stone (ABD/Pelvis w/o)
☐	☐	Abdomen Only
☐	☐	Pelvis Only
☐		Other _____

NUCLEAR MEDICINE

BONE SCAN

- ☐ Whole Body
- ☐ Multiple Specific Area
  - ☐ 3-Phase
- ☐ Liver/Spleen Scan
- ☐ Hepatobiliary (HIDA)
  CCK Ejection Fraction:
  ☐ w ☐ w/o
- ☐ Cardiac MUGA Scan
- ☐ Indium WBC Scan
- ☐ Parathyroid Scan
- ☐ Thyroid Uptake and Scan
- ☐ I-131 Whole Body Scan
- ☐ Renal Scan
  - ☐ Flow and Function
- ☐ Other _____

PET/CT

- ☐ Eyes to Thigh
- ☐ Whole Body

PET/CT (CONTINUED)

- ☐ PET Pylarify for Prostate
- ☐ PET Other (limited)
- ☐ PET Dotatate for Neuroendocrine Tumors

ULTRASOUND

- ☐ Gallbladder / Liver (RUQ)
- ☐ Abdomen complete
- ☐ Renal / Kidney (incl. Bladder)
- ☐ Pelvic (w/ Endovag if indicated)
- ☐ Endovaginal only
- ☐ Thyroid / Neck
- ☐ Thyroid / Biopsy
- ☐ Testicular / Scrotum (including Doppler)
- ☐ Carotid Doppler
- ☐ Extremity: Venus Doppler
  ☐ L ☐ R ☐ Upper ☐ Lower
- ☐ Other _____

MRI

HEAD/NECK

w	w/o	
☐	☐	Brain
☐	☐	Orbit
☐	☐	Face
☐	☐	Neck
☐	☐	TMJ

SPINE

w	w/o	
☐	☐	Cervical Spine
☐	☐	Thoracic Spine
☐	☐	Lumbar Spine
☐	☐	Sacrum

BODY

w	w/o		
☐	☐	Chest	
☐	☐	Abdomen	☐ MRCP
☐	☐	Pelvis	
☐	☐	Extremity	☐ L ☐ R
		Area of interest	☐ L ☐ R
		_____	
☐	☐	Extremity Joint	
		Area of Interest	
		_____	
☐		Other _____	

RADIOGRAPHY (PLAIN FILMS)

THORAX

- ☐ Chest PA and Lateral
- ☐ Decub Chest ☐ L ☐ R
- ☐ Ribs ☐ L ☐ R ☐ Bilat

ABDOMEN

- ☐ KUB
- ☐ Flat & Upright (Obstruct. Series)
- ☐ Acute Abd Series (include PA Chest)
- ☐ Decub Abdomen
  ☐ L ☐ R ☐ Bilat

HEAD

- ☐ Facial Bones
- ☐ Sinus Limited (Waters view)
- ☐ Sinus

EXTREMITIES/PELVIS

- ☐ Fingers: spec _____
- ☐ Hand ☐ L ☐ R
- ☐ Wrist ☐ L ☐ R
- ☐ Forearm ☐ L ☐ R
- ☐ Elbow ☐ L ☐ R
- ☐ Humerus ☐ L ☐ R
- ☐ Clavicle ☐ L ☐ R
- ☐ Shoulder ☐ L ☐ R
- ☐ Toes: spec _____
- ☐ Foot ☐ L ☐ R
- ☐ Calcaneous ☐ L ☐ R
- ☐ Ankle ☐ L ☐ R
- ☐ Tibia/Fibula ☐ L ☐ R
- ☐ Knee ☐ L ☐ R
- ☐ Standing Knee ☐ L ☐ R
- ☐ Femur ☐ L ☐ R
- ☐ Hip ☐ L
- ☐ Pelvis ☐ R
- ☐ Other _____

INTERVENTIONAL RADIOLOGY

(please send patient for INR — cannot be older than 2 weeks)

- ☐ Port Placement
- ☐ Port Removal
- ☐ PICC Line
- ☐ G Tube Placement
- ☐ Pleurex Catheter-pleural
- ☐ Pleurex Catheter-peritoneal
- ☐ Thoracentesis
- ☐ Paracentesis
- ☐ Kypho/Vert Aug (spine) Level _____
- ☐ RFA spine Level _____
- ☐ Other _____

*PET Pylarify and PET Dotatate will require supporting documentatiuon (physician notes, labs, ie PSA) to verify criteria has been met for imaging.

Physician Signature _____ Physician Printed Name _____

Physician Address (if CD is to be mailed) _____

Physician Office Phone Number _____