UVA Health

0700001

PLACE LABEL HERE

Ordering Date_____

MRN#_____

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

DEPARTMENT OF RADIOLOGY & MEDICAL IMAGING CT DOWNTIME REQUEST FORM

Please Fax to Radiology Dept.

Patient Name:_____ Patient Location _____ 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 #

Referring Clinic/Office Where Report Should Be Sent	Phone Number of Contact Person Name	Box & Fax Number

STUDY DESIRED (Circle Side if appropriate)

X	Study		X	Study			
	CT Procedures			Cardiac CT (EP LabPre-Ablation)			
	CT Brain	(3D recon as medically necessary)		Cardiac or Coronary CT/CTA (All other Areas)			
	CT Facial Bones/Orbits	(3D recon as medically necessary)		CT IVP			(3D recon as medically necessary)
	CT Temporal Bone	(3D recon as medically necessary)		CT Angio Head			(3D recon as medically necessary)
	CT Sinus	(3D recon as medically necessary)		CT Angio Neck			(3D recon as medically necessary)
	CT Soft Tissue Neck	(3D recon as medically necessary)		CT Angio Chest			(3D recon as medically necessary)
	CT Cervical Spine	(3D recon as medically necessary)		CT Angio Abdomen			(3D recon as medically necessary)
	CT Thoracic Spine	(3D recon as medically necessary)		CT Angio Pelvis			(3D recon as medically necessary)
	CT Lumbar Spine	(3D recon as medically necessary)		CT Angio Upper Extrem	LT	RT	(3D recon as medically necessary)
	CT Chest	(3D recon as medically necessary)		CT Angio Lower Extrem	LT	RT	(3D recon as medically necessary)
	CT Abdomen	(3D recon as medically necessary)		CT Angio Aorta Illeofem Runoff			(3D recon as medically necessary)
	CT Pelvis	(3D recon as medically necessary)		CT Upper Extrem	LT	RT	(3D recon as medically necessary)
	CT Virtual Colonoscopy	(3D recon as medically necessary)		CT Lower Extrem	LT	RT	(3D 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-10 Dx Code (Mandatory):

Protocol (Internal Use ONLY):

CT IMAGING REQUEST

Physician Signature_____

Does Patient have Contrast allergy?_____ ***CREATININE:***_____ ***DATE:***_____

If patient is taking Glucophage or generic metformin please check next box;

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.