

UNIVERSITY OF VIRGINIA HEALTH SYSTEM DEPARTMENT OF RADIOLOGY/UVA IMAGING DIAGNOSTIC REQUEST FORM

PLACE LABEL HERE

Ordering Date _____

SS# _____

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

Please **Fax** to (434) 243-6999--Hosp East or 243-0307-UVA Imaging @ Fontaine
Schedule at (434) 243-6888-Hosp East or 243-0321-UVA Imaging @ Fontaine

Patient Name: _____ 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	X	Study
	<u>Skull</u>		<u>Chest</u>		<u>Upper Extremities</u>
	Skull		PA Chest		AC Joints
	Sinuses		PA/LAT Chest		Shoulder Lt Rt
	Facial Bones		Ribs w/o CXR Lt Rt		Scapula Lt Rt
	Nasal Bones		Ribs w/CXR Lt Rt		Humerus Lt Rt
	<u>Spine</u>		Bilat Ribs		Elbow Lt Rt
	Cervical Spine-Trauma		Bilat Ribs w/CXR		Forearm Lt Rt
	Cervical Spine-Pain		Sternum		Wrist Lt Rt
	Thoracic Spine		<u>Abdomen</u>		Hand Lt Rt
	Thoracolumbar Spine		1 View		Finger(s) Lt Rt
	Lumbar Spine-Trauma		Flat/Upright		<u>Lower Extremities</u>
	Lumbar Spine-Pain		Acute Abd w/PA CXR		Femur Lt Rt
	Scoliosis Study		<u>Pelvis</u>		Knee Lt Rt
	SI Joints		1 or 2 views		Standing Knees
	Sacrum/Coccyx		HIP -1Vw Lt Rt		Tib/Fib Lt Rt
			HIP -2Vws Lt Rt		Ankle Lt Rt
	<u>DEXA-Bone Density</u>				Os Calcis Lt Rt
			<u>BONE AGE FILM</u>		Foot Lt Rt
					Toe(s) Lt Rt

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Other Study-Not Listed (Specify):

Clinical Indications for Exam (Mandatory):

ICD-9 Dx Code(Mandatory):

Physician Signature: _____

Special considerations: Non-English speaking Sz disorder Pregnancy

If films were taken within 2 weeks prior to scan from outside UVA please instruct pt to bring films.

Does patient require early reading? Yes No Films to Go with Patient After Reading? Yes No

