

CT IMAGING ORDER FORM

Patient Information

Patient Name		DOB	
Phone	Email		
Address	City	State	Zip

Provider Information

Provider Name		NPI	
Office Name			
Office Address	City	State	Zip
Office Phone	Fax		

CT	
Abdomen	<input type="checkbox"/> w/o (74150) <input type="checkbox"/> w/ (74160) <input type="checkbox"/> w/ & w/o (74170)
Abdomen & Pelvis	<input type="checkbox"/> w/o (74176) <input type="checkbox"/> w/ (74177) <input type="checkbox"/> w/ & w/o (74178)
Brain/Head	<input type="checkbox"/> w/o (70450) <input type="checkbox"/> w/ (70460) <input type="checkbox"/> w/ & w/o (70470)
Calcium Score	<input type="checkbox"/> w/ & w/o (75571)
Chest	<input type="checkbox"/> w/o (71250) <input type="checkbox"/> w/ (72160) <input type="checkbox"/> w/ & w/o (71270)
Cervical Spine	<input type="checkbox"/> w/o (72125) <input type="checkbox"/> w/ (72126) <input type="checkbox"/> w/ & w/o (72127)
Lower Extremity <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> w/o (73700) <input type="checkbox"/> w/ (73701) <input type="checkbox"/> w/ & w/o (73702)
<input type="checkbox"/> Ankle <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Foot <input type="checkbox"/> Lower Leg <input type="checkbox"/> Thigh	
Lumbar Spine	<input type="checkbox"/> w/o (72131) <input type="checkbox"/> w/ (72132) <input type="checkbox"/> w/ & w/o (72133)
Maxillofacial/Sinus	<input type="checkbox"/> w/o (70486) <input type="checkbox"/> w/ (70487) <input type="checkbox"/> w/ & w/o (70488)
Pelvis	<input type="checkbox"/> w/o (72192) <input type="checkbox"/> w/ (72193) <input type="checkbox"/> w/ & w/o (72194)
Neck	<input type="checkbox"/> w/o (70490) <input type="checkbox"/> w/ (70491) <input type="checkbox"/> w/ & w/o (70492)
Orbits/Sella/IACs	<input type="checkbox"/> w/o (70480) <input type="checkbox"/> w/ (70481) <input type="checkbox"/> w/ & w/o (70482)
Thoracic Spine	<input type="checkbox"/> w/o (72128) <input type="checkbox"/> w/ (72129) <input type="checkbox"/> w/ & w/o (72130)
Upper Extremity <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> w/o (73200) <input type="checkbox"/> w/ (73201) <input type="checkbox"/> w/ & w/o (73202)
<input type="checkbox"/> Elbow <input type="checkbox"/> Shoulder <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Upper Arm <input type="checkbox"/> Forearm	
<input type="checkbox"/> Lung Cancer Screening (G0297)	
Other : _____	

CT Angiogram	
<input type="checkbox"/> Abdomen (74175)	
<input type="checkbox"/> Abdomen & Pelvis (74174)	
<input type="checkbox"/> Head/Brain (70496)	
<input type="checkbox"/> Carotids (70498)	
<input type="checkbox"/> Chest (71275)	
<input type="checkbox"/> Heart/Coronaries (75574)	
<input type="checkbox"/> Lower Extremity (73706) <input type="checkbox"/> R <input type="checkbox"/> L	
<input type="checkbox"/> Ankle <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Foot <input type="checkbox"/> Lower Leg <input type="checkbox"/> Thigh	
<input type="checkbox"/> Pelvis (72191)	
<input type="checkbox"/> Pulmonary (75572)	
<input type="checkbox"/> Run-Offs (75635)	
<input type="checkbox"/> Upper Extremity (73206) <input type="checkbox"/> R <input type="checkbox"/> L	
<input type="checkbox"/> Elbow <input type="checkbox"/> Shoulder <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Upper Arm <input type="checkbox"/> Forearm	
Other : _____	

Special Instructions:

Diagnosis/Indications:	ICD-10 Codes:
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Physician Signature : _____ Date : _____