



ARCADIA RADIOLOGY MEDICAL GROUP

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STAT	<input type="checkbox"/> APPOINTMENT
	Fax to: (626) 447-2924
	<input type="checkbox"/> REPORT

IMPORTANT: BRING THIS FORM WITH YOU TO YOUR APPOINTMENT

Patient Name _____ DOB _____ Appt: Date _____ Time _____
First Middle Last

SIGNS/SYMPTOMS: ACUTE CHRONIC _____

MRI

Creatinine levels are required for all patients 60 yrs. +
 Contrast, if indicated

<input type="checkbox"/> Brain	<input type="checkbox"/> Spine <input type="checkbox"/> C <input type="checkbox"/> T <input type="checkbox"/> L
<input type="checkbox"/> IAC's - 7th & 8th Nerve	<input type="checkbox"/> Soft Tissue Neck
<input type="checkbox"/> Pituitary/Sella	<input type="checkbox"/> Abdomen _____
<input type="checkbox"/> Orbits	<input type="checkbox"/> Pelvis <input type="checkbox"/> TMJ
<input type="checkbox"/> Extremity _____	R L

MRA

Brain Carotid Arteries

Aorta - Specify: Thoracic Abdominal Iliac Arteries

Runoff (Abd., Aorta, Lwr. Ext.) Renal

Breast MRI Unilateral - R L Bilateral

Other (Specify) _____

CT

Creatinine levels are required for all patients 60 yrs. +
 IV Contrast Oral Contrast 3D Recon. (If Necessary)

<input type="checkbox"/> Brain	<input type="checkbox"/> Chest <input type="checkbox"/> Spine <input type="checkbox"/> C <input type="checkbox"/> T <input type="checkbox"/> L
<input type="checkbox"/> Orbits	<input type="checkbox"/> Chest (HRCT - For Interstitial Lung Disease)
<input type="checkbox"/> Sinuses	<input type="checkbox"/> Abdomen <input type="checkbox"/> Soft Tissue Neck
<input type="checkbox"/> InstaTrak Sinus	<input type="checkbox"/> Temporal Bones <input type="checkbox"/> Pelvis
<input type="checkbox"/> QCT	<input type="checkbox"/> Renal
<input type="checkbox"/> Biopsy/Epidural	Pre-approval by Radiologist needed
<input type="checkbox"/> Extremity _____	R L

CTA

Brain Carotid Arteries Pulmonary

Aorta - Specify: Thoracic Abdominal Iliac Arteries

Runoff (Abd., Aorta, Lwr. Ext.) Renal

Cardiac CTA

Other (Specify) _____

ARTHROGRAM

MRI CT

Specify _____

ULTRASOUND

<input type="checkbox"/> Carotid Arteries	<input type="checkbox"/> OB	<input type="checkbox"/> Pelvic	<input type="checkbox"/> Transvaginal
<input type="checkbox"/> Aorta	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Prostate	<input type="checkbox"/> Testicular
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Renal (Kidneys/Bladder)	<input type="checkbox"/> Breast - R L B	
<input type="checkbox"/> Arterial _____	<input type="checkbox"/> Venous _____		
<input type="checkbox"/> Biopsy - Specify: <input type="checkbox"/> Breast <input type="checkbox"/> Thyroid	Specify: R L B		

Other (Specify) _____

MAMMOGRAPHY

Screening Ultrasound (If necessary)

Diagnostic Unilateral - R L Bilateral Implants

X-RAY

Complete Limited

<input type="checkbox"/> Pelvis	<input type="checkbox"/> Ribs	<input type="checkbox"/> Abdominal Series
<input type="checkbox"/> Chest <input type="checkbox"/> 1v <input type="checkbox"/> 2v	<input type="checkbox"/> Scoliosis Series	
<input type="checkbox"/> Sinuses	<input type="checkbox"/> KUB	<input type="checkbox"/> Spine <input type="checkbox"/> C <input type="checkbox"/> T <input type="checkbox"/> L
<input type="checkbox"/> Extremity _____	R L	

Other (Specify) _____

FLUOROSCOPY

<input type="checkbox"/> Esophagram	<input type="checkbox"/> Hysterosalpingogram
<input type="checkbox"/> Upper GI Series	<input type="checkbox"/> Barium Enema
<input type="checkbox"/> Small Bowel Series	<input type="checkbox"/> IVP

Other (Specify) _____

PHYSICIAN(S)

Initiation of Prior Authorization Disclaimer & Medicare Rules

THE PRESCRIBER OF A SERVICE THAT IS SUBJECT TO PRIOR AUTHORIZATION MUST DIRECTLY REQUEST THE PRIOR AUTHORIZATION.

All services requiring prior authorization should be faxed to Arcadia Radiology Medical Group before services are rendered. Some tests may require advance scheduling. Medicare Rules require that tests ordered on patients must be medically necessary. Claims denied for screening purposes and tests that are deemed not medically necessary by Medicare and other third party payers may result in patient billing. A patient's signature is required on a separate Advanced Beneficiary form (ABN).

PHYSICIAN SIGNATURE _____ **Date** _____

PRINT OR OFFICE STAMP

Physician _____
Phone _____
Fax _____