Georgia Health Imaging

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Patient Centered Technology At Your Service

Radiology Order / Precertification Form

Patient Name _____
DOB _____ Age _____ Sex _____
Tel _____
☐ Send CD ☐ Fax Report ☐ STAT-Call with report

Diagnosis (ICD 10)_____
Special Instructions_____
Office Contact _____
Pre-Cert. # _____
Referring Doctor NPI _____

MRI/MRA

☐ W/O Contrast
☐ W Contrast
☐ W and W/O Contrast
☐ Bilateral
☐ Radiologist Discretion

☐ Brain
☐ Brain IAC's
☐ Brain Pituitary
☐ Soft Tissue Neck
☐ Abdomen
☐ Pelvis
☐ Brachial Plexus

☐ Cervical Spine
☐ Lumbar Spine
☐ Thoracic Spine
☐ MRA: Circle of Willis
☐ MRA: Neck
☐ Hip R L
☐ Other _____

Extremities

☐ Shoulder	R	L
☐ Elbow	R	L
☐ Wrist	R	L
☐ Knee	R	L
☐ Hand/Fingers	R	L
☐ Foot/Toes	R	L

ULTRASOUND

General
☐ Abdomen
☐ Breast
☐ Vaginal
☐ Pelvis
☐ Gall Bladder
☐ Liver
☐ Thyroid
☐ Scrotal
☐ Aorta
☐ Neonatal
☐ Renal
☐ Musculoskeletal
☐ Echocardiogram
☐ Other_____

Vascular
☐ Carotid
☐ Arterial
☐ Lower Extremity
☐ Upper Extremity
☐ Venous
☐ Single ☐ Bilateral
☐ Aortic Dopplar
☐ Transcranial Dopplar
☐ ABI
☐ Single ☐ Bilateral
☐ Renal Dopplar
☐ OB

CT SCAN

☐ W/O Contrast ☐ W Contrast ☐ W & W/O Contrast

**** BUN and Creatinine levels are required for all patients having contrast studies over the age over 40 or diabetic ****

☐ Soft Tissue
☐ Neck
☐ Sinus
☐ Chest
☐ Orbits
☐ Facial Bones
☐ Temporal Bones
☐ Sinuses Screening
☐ Lung Screening
☐ Other _____

☐ Abdomen
☐ Head/Brain
☐ Pelvis
☐ TMJ
☐ Sinuses Full
☐ Renal Stones

☐ Cervical Spine
☐ Lumbar Spine
☐ Thoracic Spine

Extremities

☐ Ankle	R	L
☐ Elbow	R	L
☐ Foot	R	L
☐ Knee	R	L
☐ Wrist	R	L
☐ Shoulder	R	L

X-RAY

X-Ray:_____

BONE DENSITY

☐ **Extremity** _____

NERVE CONDUCTION

☐ Bilateral Upper NCV
☐ Bilateral Lower NCV
☐ Upper NCV with EMG
☐ Lower NCV with EMG
Other: _____

I have requested the above exam(s) based on the patient's history and diagnosis. The exam(s) are necessary to diagnose accurately and develop a sound treatment plan. *** Please include all doctor's notes for all insurance patients in order to ensure authorization. ***

Physician Name _____ Physician Email _____

Tel_____ Fax _____

Date _____ Office Contact _____

Physician Signature _____

Preparation Instructions for Adult Patients

Please call 678-924-0964 for instructions for pediatric patients or if you have any additional questions.

Ultrasound:
If your procedure is listed below, follow the instructions to prepare for your exam. All other ultrasounds require no preparation. Diabetic patients and those with other needs should call us at 678-924-0964 for instructions.

Pelvic or Obstetric:

- Female Patients **must** drink **six glasses** of water one hour before the exam and should not urinate. The urinary bladder must be full for the examination.

Gallbladder/Abdomen:

- Eat a fat free dinner the day before your exam (lean meats, fresh vegetables, toast or bread). DO NOT EAT eggs, butter, or fried foods.
- Do not eat or drink anything after midnight the day before your exam.
- Do not eat or drink anything the day of your exam until after your exam is complete.

CT Scan:

Abdomen/Pelvis:

- Do not eat or drink anything **four hours** prior to your exam.

Contrast Exam/IPV

- Call us the day before your exam if you are allergic to iodine or fish products.
- Eat a fat free dinner the day before your exam (lean meats, fresh vegetables, toast or bread). DO NOT EAT eggs, butter, or fried foods.
- Do not eat or drink anything after midnight the day before your exam.

GI Studies:

- Do not eat or drink anything after midnight.

MRI:
Please notify us if you have any of the following:

- Pacemaker
- Aneurysm clips
- Metal Fragments
- Any other metal implants/body art not mentioned above