Piedmont Athens Regional

Oconee Health Center • 1305 Jennings Mill Road
Watkinsville, Georgia 30677
P: 706.552.1980 **F:** 706-475-6791

piedmont.org/athens

Patient Name: ____________________ SSN: ____________
Date of Birth: ____________ Daytime Phone: ____________
Appt. Preference: ____________ **Confirmed Appt:** ____________
Referring Physician: ____________ Phone: ____________
Diagnosis and ICD-10 Code: ____________________
Insurance Co: ____________ Phone: ____________
Policy ID: ____________ Insured: ____________
Medicare Primary? ❑ Yes ❑ No Precertification (if needed): ____________
Research/Clinical trial? ❑ Yes ❑ No

PLEASE CHECK ALL THAT APPLY:

- ❑ **HOSPITAL WILL COMPLETE PRECERT (CLINICALS REQUIRED)**
- ❑ **HOSPITAL WILL SCHEDULE PATIENT**

SPECIAL REQUEST

Check all that apply

- ❑ STAT
- ❑ Call Report **Phone:** ____________
- ❑ Wheelchair Assistance
- ❑ Language Services

FOR IV CONTRAST EXAMS ONLY (CT AND MRI)

Current BUN and CREATININE and/or GFR
(Must be less than 6 weeks prior to exam date)

- ❑ Yes, Please fax the lab results along with this order form
- ❑ No, Please check the order below:
  BUN: ________ Creatinine: ________ GFR: ________

DIAGNOSTIC X-RAY

ABDOMEN AND GI TRACT

- ❑ Abdomen (KUB)
- ❑ Abdomen (Flat & Upright)
- ❑ Abdomen Series
- ❑ Colonic Transit
- ❑ Other: ____________________

CHEST

- ❑ Sternum
- ❑ SC Joints
- ❑ Chest PA
- ❑ Chest PA and Lateral
- ❑ Rib Series: Bilateral: ________
- ❑ Other: ____________

SKULL AND FACE

- ❑ Skull Series
- ❑ Sinus Series
- ❑ Mandible
- ❑ Nasal Bones
- ❑ Facial Bone

SPINE AND PELVIS

❑ **AP/LAT** ❑ **Flexion & Extension** ❑ **Complete**

- ❑ Cervical Spine
- ❑ Lumbar Spine
- ❑ Thoracic Spine
- ❑ Pelvis
- ❑ Scoliosis Series
- ❑ Neck Soft Tissue
- ❑ SI joints
- ❑ Sacrum/Coccyx
- ❑ Other: ____________________

EXTREMITIES

Upper ❑ **Right** ❑ **Left**

- ❑ Elbow
- ❑ Finger(s)
- ❑ Forearm
- ❑ Hand
- ❑ Humerus
- ❑ Shoulder
- ❑ Wrist Complete

Lower ❑ **Right** ❑ **Left**

- ❑ Ankle Complete
- ❑ Femur
- ❑ Foot
- ❑ Hip
- ❑ Knee 2-View
- ❑ Knee Complete
- ❑ OSCalcis
- ❑ Pelvis, AP
- ❑ Tibia/Fibula
- ❑ Toe(s)
- ❑ Standing Knees

SURVEYS

- ❑ Osseous Survey
- ❑ Bone Age

MRI

❑ **With IV Contrast** ❑ **Without IV Contrast** ❑ **With & Without IV Contrast**

- ❑ Brain ❑ C-Spine ❑ Thoracic Spine ❑ Lumbar Spine ❑ Cardiac
- ❑ Abdomen: Please Specify: ____________________
- ❑ Extremity: Please Specify: ____________________
  Left: ________ Right: ________
- ❑ MRA: Please Specify: ____________________
- ❑ Other: Please Specify: ____________________

CT

❑ **With IV Contrast** ❑ **Without IV Contrast** ❑ **With & Without IV Contrast**

- ❑ Head/Brain
- ❑ Chest
- ❑ Soft Tissue Neck
- ❑ Sinuses
- ❑ Cardiac Scoring
- ❑ Pelvis
- ❑ Abdomen
- ❑ Renal Stone Study
- ❑ IACs (Mastoids)
- ❑ Enterography
- ❑ C-Spine
- ❑ L-Spine
- ❑ T-Spine
- ❑ Max-facial
- ❑ Orbits
- ❑ Lower Extremity: Please Specify: ____________
  Left: ________ Right: ________
- ❑ Upper Extremity: Please Specify: ____________
  Left: ________ Right: ________

The protocol for all abdomen & pelvis scans requires oral contrast unless otherwise indicated by the physician.

- ❑ NO ORAL CONTRAST
- ❑ Other: ____________________

CTA

❑ **With IV Contrast** ❑ **Without IV Contrast** ❑ **With & Without IV Contrast**

- ❑ CT Angio Abdomen
- ❑ CT Angio Lower Extremity
- ❑ CT Angio Abdomen (with runoff)
- ❑ CT Angio Neck
- ❑ CT Angio Chest
- ❑ CT Angio Pelvis
- ❑ CT Angio Head
- ❑ CT Angio Upper Extremity

ULTRASOUND

- ❑ RUQ (GB pancreas, liver, bile duct, right kidney)
- ❑ Abdomen Complete
- ❑ Fatty meal delay scan (Performed with a RUQ scan)
- ❑ Hepatic Vein Doppler (Prox IVC, hepatic veins and artery, main portal vein, splenic vein)
- ❑ Spleen
- ❑ Pelvic with Endovaginal
- ❑ Kidneys (renals)
- ❑ Pelvic without Endovaginal
- ❑ Aorta
- ❑ Thyroid
- ❑ Cranial
- ❑ Head/Neck
- ❑ Appendix
- ❑ Testicle with Doppler
- ❑ Extremity (non-vascular)
- ❑ Fetal
- ❑ Other: ____________________

Radiology professional services are provided by Athens Radiology Associates and will be billed separately. I certify the need for these services furnished under this plan of treatment while under my care.

Physician signature: ____________________

Date: ____________ Time: ____________

PATIENT LABEL