Prime
MEDICAL IMAGING

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DATE: _____

PATIENT'S NAME: _____

PATIENT'S PHONE#: _____ DOB: _____

PHYSICIAN: _____

CLINICAL HISTORY/INDICATION: _____

RQI #/Pre-certification: _____

Date: _____

ICD-10: _____

cc/NAME: _____ FAX NUMBER: _____

PHYSICIAN'S SIGNATURE: _____

If clinical decision support (CDS) software utilized, please specify vendor and approval: _____

PERTINENT CLINICAL DIAGNOSIS REQUIRED

PLEASE PROVIDE SPECIFIC ICD-10 CODES AND WHEN POSSIBLE: SYMPTOMS, LOCATION, DURATION, AND PERTINENT PAST HISTORY. (PLEASE DO NOT USE "RULE OUT", "POSSIBLE", ETC.)

COMMENTS: _____

☐ INTRAVENOUS CONTRAST PER RADIOLOGIST (IF YOU DO NOT SELECT THIS OPTION, PLEASE SELECT A CONTRAST OPTION WHERE APPLICABLE.)

☐ ON-SITE BUN/CR TESTING IF NEEDED

MRI

- wo w/wo BRAIN
- w/wo IAC'S
- w/wo BRAIN & IAC'S
- w/wo PITUITARY
- w/wo ORBITS
- wo w/wo CERVICAL SPINE
- wo w/wo THORACIC SPINE
- wo w/wo LUMBAR SPINE
- R L w/wo BRACHIAL PLEXUS
- wo INTRACRANIAL MRA
- wo w/wo CAROTID/NECK MRA
- w/wo THORACIC AORTA MRA
- w/wo ABDOMINAL AORTA/RENAL MRA
- w/wo UE/LE PERIPHERAL MRA
- wo w/wo NECK SOFT TISSUE
- wo w/wo CHEST
- wo w/wo **ABDOMEN**
  - ☐ LIVER ☐ PANCREAS/MRCP
  - ☐ RENAL
  - ☐ ABDOMEN OTHER: _____
- wo w/wo **PELVIS**
  - ☐ BONY ☐ SI JOINTS
  - ☐ UTERUS/OVARIES
  - ☐ HERNIA PROTOCOL
  - ☐ SOFT TISSUES SPECIFY: _____
- ☐ w/wo **PROSTATE**
  - URONAV / SEGMENTATION

ULTRASOUND

- ABDOMEN COMPLETE
- LIVER/GB/PANCREAS (RUQ)
- KIDNEY/BLADDER
- THYROID
- SCROTAL/TESTICULAR
- PELVIC TRANSABD & TRANSVAG
- CAROTID DOPPLER
- AORTA
- R L B LE VENOUS DOPPLER
- OBSTETRIC
- ☐ 1st Trimester w EV if needed
- ☐ OB other: _____

MUSCULOSKELETAL MRI

- R L HIP ☐ with arthrogram
- R L SHOULDER ☐ with arthrogram
- R L ELBOW ☐ with arthrogram
- R L WRIST ☐ with arthrogram
- R L HIP OSSEOUS & PELVIS
- R L KNEE ☐ with arthrogram
- R L LEG (TIBIA/FIBULA)
- R L ANKLE/HINDFOOT
- R L FOREFOOT
- R L ( )

X-RAY

- ORBITS for MRI
- CHEST PA & LATERAL
- ABDOMEN ☐ SUPINE ☐ SUPINE/UPRIGHT
- 3 5 F/E CERVICAL SPINE
- THORACIC SPINE
- 3 5 F/E LUMBAR SPINE
- SCOLIOSIS
- BONE AGE (L HAND)
- JOINTS AND EXTREMITIES
- R L B _____
- R L B _____
- R L B _____
- X-RAY OTHER: _____

POST-OP JOINT AND SPINE CT SCAN (Metal Suppression Technique)

- R L SHOULDER
- R L KNEE
- R L HIP
- R L FOOT/ANKLE
- SPINE
  - ☐ CERVICAL ☐ THORACIC
  - ☐ LUMBAR

CT SCAN

- wo w/wo w BRAIN
- wo w/wo w ORBITS
- wo SINUSES
- wo FACIAL BONES
- w/wo w NECK SOFT TISSUE
- wo w CHEST
- w PE CHEST (CTA)
- wo w/wo w ABDOMEN / PELVIS
- wo RENAL STONE STUDY
- w/wo CT UROGRAM
- CERVICAL SPINE
- THORACIC SPINE
- LUMBAR SPINE
- R L B SHOULDER/ELBOW/WRIST
- R L B HIP/KNEE/ANKLE/FOOT
- 3D RECONSTRUCTION
- CT CALCIUM SCORE

CT ANGIOGRAPHY (CTA)

- CAROTID/NECK CTA
- THORACIC AORTA CTA
- ABDOMINAL AORTA CTA
- LE UE PERIPHERAL CTA
- INTRACRANIAL CTA

COMMENTS:

BREAST IMAGING

SCREENING MAMMOGRAPHY (DIGITAL 3D)

- ☐ ANNUAL (NO SYMPTOMS OR ABNORMAL PHYSICAL EXAM)
- ☐ SCREENING BREAST ULTRASOUND FOR DENSE BREASTS
- ☐ DIAGNOSTIC VIEW AND/OR ULTRASOUND IF ABNORMAL SCREENING MAMMOGRAM

DIAGNOSTIC MAMMOGRAPHY (Digital 3D)

- ☐ BILATERAL ☐ RIGHT ☐ LEFT
- ☐ ULTRASOUND IF INDICATED AT THE DISCRETION OF THE RADIOLOGIST

BREAST ULTRASOUND

- ☐ BILATERAL ☐ RIGHT ☐ LEFT
- ☐ SCREENING FOR DENSE BREASTS

☐ PRIORITY READING - Please provide contact telephone number (_____)