CT REQUEST/INTERPRETATION FORM

NAME:_____**DOB:**_____**SEX**____**RACE:**_____

Chart #:_____**Patient Phone #:**_____

Date of Appointment:_____**Time:**_____

Auth # - include beginning and end date:_____

Called STAT ☐ **Fax, Phone or Pager #:**_____**Fax Results To:**_____

Pertinent Clinical History:_____

DX: (Signs/Symptoms): (ICD 10 Code)_____

Physician's Signature: _____ **Printed Name:**_____
Signature/Date

IV CONTRAST ALLERGY: ☐ **Yes** ☐ **No** **Contact Phone #:** _____

CREATININE LEVEL – WITHIN 30 DAYS – REQUIRED FOR PATIENTS RECEIVING IV CONTRAST WITH ANY OF THE FOLLOWING CONDITIONS/HISTORY:

☐ **DIABETES**
☐ **KIDNEY DISEASE/SOLITARY KIDNEY**
☐ **HYPERTENSION (OR MEDS FOR HTN)**
☐ **HEART DISEASE**
☐ **HISTORY OF CANCER/CHEMOTHERAPY (WITHIN LAST 30DAYS)**

_____**CREATININE** _____**DATE DRAWN (must be within last 30 days)**

EXAM REQUESTED

CT HEAD
☐ W/CONTRAST
☐ W/O CONTRAST
☐ W & W/O CONTRAST

CT ORBIT, SELLA, OR IAC'S
☐ W/CONTRAST
☐ W/O CONTRAST

CT SINUS/MAXILLOFACIAL
☐ W/CONTRAST
☐ W/O CONTRAST

CT SOFT TISSUE NECK
☐ W/CONTRAST
☐ W/O CONTRAST

CT CHEST-HIGH RESOLUTION
☐ W/CONTRAST
☐ W/O CONTRAST

CT CHEST
☐ W/CONTRAST
☐ W/O CONTRAST

CT ABDOMEN
☐ W/CONTRAST
☐ W/O CONTRAST
☐ W & W/O CONTRAST

CT PELVIS
☐ W/CONTRAST
☐ W/O CONTRAST
☐ W & W/O CONTRAST

CTA (ANGIO/ARTERIAL STUDIES)
☐ CHEST PE DISSECTION
☐ ABDOMEN
☐ THORACIC W & W/O CONTRAST
☐ PELVIS
☐ AORTA/BILATERAL RUNOFF
☐ HEAD (CIRCLE OF WILLIS)
☐ NECK (CAROTID)
☐ UPPER EXTREMITY
☐ LOWER EXTREMITY

CT UPPER EXTREMITY
☐ W/CONTRAST
☐ W/O CONTRAST

CT LOWER EXTREMITY
☐ W/CONTRAST
☐ W/O CONTRAST

CT CERVICAL SPINE
☐ W/CONTRAST
☐ W/O CONTRAST

CT THORACIC SPINE
☐ W/CONTRAST
☐ W/O CONTRAST

CT LUMBAR SPINE
☐ W/CONTRAST
☐ W/O CONTRAST

ABDOMEN & PELVIS
☐ W & W/O CONTRAST

ADDITIONAL INSTRUCTIONS: _____