CT REQUEST/ INTERPRETATION FORM

NAME: _____ DOB: _____ SEX: ___ RACE: _____

CHART #: _____ PATIENT PHONE #: _____

DATE OF APPOINTMAENT: _____ TIME: _____

AUTH #- Including beginning & end date: _____

CALLED STAT ☐ FAX, PHONE OR PAGER #: _____ FAX RESULTS TO: _____

PERTINENT CLINICAL HISTORY: _____

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

PHYSICIAN (Sign &Date): _____ PRINT NAME: _____

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 (MEDS HTN)

☐HISTORY OF CANCER/ CHEMOTHERAPY (WITHIN 30 DAYS) ☐ HEART DISEASE

CREATININE: _____ DATE DRAWN (Within 30 days): _____

EXAM REQUESTED

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

CT ORBIT, SELLA OR IACS
- ☐ 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)
- ☐ CHEST PE
- ☐ ABDOMEN
- ☐ PELVIS
- ☐ AORTA/ BILAT. RUNOFF
- ☐ HEAD (CIRCLE OF WILLIS)
- ☐ NECK (CAROTID)
- ☐ UPPER EXTREMITY
- ☐ LOWER EXTREMITY
- ☐ CHEST W/ & W/O (DISSECTION)
- ☐ CHEST W/ & W/O (PULM VIENS)

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 ABDOMEN/ PELVIS
- ☐ W/ CONTRAST
- ☐ W/O CONTRAST
- ☐ W/ & W/O CONTR

ADDITIONAL INSTRUCTIONS: _____