KAISER PERMANENTE®

REGIONAL RADIOLOGY SERVICES

ORDER FORM

PLEASE NOTE THAT ALL HIGHLIGHTED PORTIONS OF THE FORM ARE NEEDED FOR THE ORDER TO BE COMPLETE

For Radiology orders:

1. Mark the requested study(ies)
2. Sign and date the form
3. Fax request to: 855-416-3847- right fax
4. Patient calls 303-338-3456 to schedule exams

Hours of operation: Mon-Fri 7am- 6pm

Patient Name (Last, First)

Health Record Number: DOB: Gender:

Phone number:

Pertinent Medical Info. (e.g. weight, allergies, lab, LMP):

Ordering/Referring clinician (Please print):

Office Phone: Fax Number:

CC:

Special Instructions: Routine (w/in 2 weeks) ASAP (1-2 Days) Stat CD: Y or N

Sign or Symptom/Diagnosis: What happened? When did it happen? Where should we focus? What are you concerned for?

ICD 10 Code:

Magnetic Resonance (MR)

Desired Study:

Contrast?
Yes □ **No** □

Cat Scan

Desired Study:

Contrast?
Yes □ **No** □

Nuclear Medicine/ PET

Desired Study:

Ultrasound

Desired Study:

Mammography

Desired Study:

Screening
Diagnostic

BMD

Desired Study:

Fluoroscopy

Desired Study:

General Radiography

Desired Study:

Right
Left
Bilateral

Ordering Clinician's Signature:

Date: