UR MEDICINE
MEDICINE of THE HIGHEST ORDER

# UR MEDICINE IMAGING

## OUTPATIENT REQUISITION

TAX ID 16-1070301

UR MEDICINE IMAGING

TODAY'S DATE: _____

APPT DATE/TIME: _____

EXAM LOCATION: _____

Patient's Name: _____

Patient's Birthdate: _____

Patient's Contact #: _____

**ORDERING/ RENDERING PROVIDER**

NAME: _____
LAST FIRST

CONTACT #: _____

FAX #: _____

**ATTENDING:** _____

**PCP:** _____

*Ordering Signature*

**Imaging Study**

- ☐ CT
- ☐ DXA
- ☐ Fluoroscopy / GI
- ☐ Interventional Procedure (Angio / Biopsy / Myelogram)
- ☐ MRI
- ☐ Mammography
- ☐ Nuclear Medicine
- ☐ Plain Film
- ☐ PET/CT
- ☐ PET/MRI
- ☐ Ultrasound

**PARTS OF BODY/ORGANS TO BE EXAMINED**

- ☐ Right
- ☐ Left
- ☐ Bilateral

**CLINICAL INDICATION** (HISTORY / DIAGNOSIS / SIGNS & SYMPTOMS)

**Diagnosis code (ICD) for imaging study:** _____

Rule out diagnosis not acceptable

**LAB REQUIREMENTS:** At least 2 days prior to exam.

- MRI/CT exams with contrast: BUN, Creatinine, eGFR
- Interventional Radiology Procedures: PLT, PT/PTT, INR

LABS PENDING AT: ☐ Strong ☐ RRH ☐ ACM

**INSURANCE AUTHORIZATIONS***

**Patient's Primary Insurance:** _____

**Subscriber ID:** _____

Pre-Authorization if applicable

| STUDY | Pre-Authorization # |
|---|---|
| | |
| | |

**Radiologist may administer or withhold contrast at their discretion:** ☐ Yes ☐ No

**Does patient have contrast allergies?** ☐ Yes ☐ No **If yes, describe:** _____

**Is patient potentially pregnant?** ☐ Yes ☐ No **Date of LMP** _____

**Does patient have renal disease?** ☐ Yes ☐ No

**Interventional Radiology Patients: Is patient on an anticoagulant?** ☐ Yes ☐ No

**Does patient have a pacemaker, neurostimulator, or implanted device?** ☐ Yes ☐ No

**If yes, what is it?** _____

11/26/24