UTSouthwestern
Medical Center

Imaging Services Order Form

Pt. Name:_____ Med. Rec. # _____

DOB: _____ Phone #: _____ - _____ - _____

Address: _____

_____

C ity State Zip

Medical/Insurance: _____

For a complete list of locations, please visit: www.utswmed.org/locations

Imaging Services Centralized Scheduling
214-645-XRAY (9729) or 817-288-9770
Fax: 214-645-9289

Today's Date: _____

Physicians should order ONLY procedures that are medically necessary for the diagnosis or treatment of the patient. The patient may have to assume financial responsibility for exams performed without acceptable indications.

Modality:
- ☐ X-Ray/Fluoro
- ☐ MRI
- ☐ CT
- ☐ Ultrasound
- ☐ DEXA Bone Density
- ☐ Mammography/Other Breast Imaging
- ☐ Nuclear Medicine
- ☐ Special Procedures
- ☐ MEG

Examination/Procedure Requested: _____

ICD-10 Code (must support procedure requested): _____

Procedure may be modified in the interest of radiological appropriateness: ☐ Yes ☐ No

Brief Clinical History which must include Signs, Symptoms, Chief Complaint and Questions to be answered by this examination: _____

_____

*(For follow-up examinations, must list **NEW** indications to document medical necessity - Federal Requirement.)*

Printed Name of Ordering Physician | Printed Name of Attending Physician | Authorized Signature

Provider Contact Number for Urgent Findings:

During Business Hours: (_____) _____
After Hours: (_____) _____
Fax: (_____) _____

****Must be signed by a MD, PA or NP. Requests without all of the above and complete contact information cannot be processed.****

Food/Drug Allergy ☐ Yes ☐ No	Creatinine Level:	Patient
IV Contrast Allergy ☐ Yes ☐ No	Date Drawn:	Height: _____ Weight: _____

Diabetic ☐ Yes ☐ No	Ambulatory ☐ Yes ☐ No ☐ Inpatient ☐ Outpatient
Pregnant? ☐ Yes ☐ No ☐ N/A If Pregnant, how many weeks? _____	Date of onset of last menstrual period: _____/_____/_____ *(Required for all female patients between ages 12 to 50 years)*

Name of person scheduling exam: _____ Phone #: ( ) _____

Schedule As: ☐ Urgent (within 24 hours) ☐ Today (First Available)
☐ Next Available Time (within 72 hours)

Patient's Phone Numbers: Home: ( ) _____ Work: ( ) _____

(Outpatients cannot be scheduled without a valid telephone number.)

Scheduling Only: Appointment scheduled for _____ _____
Time Date

PAPER ORD