

If procedure is scheduled by physician's office staff

PLEASE write the exact order and diagnosis that was given to the scheduler
THIS REQUEST MUST ACCOMPANY THE PATIENT AT THE TIME OF SERVICE.

Patient Name(Last, First): _____ DOB: _____

| Diagnostic Radiology | CPT | Lower Extremity | CPT | CT Scan | CPT |
|-----------------------------------|-------|---|-------|---|---------|
| Chest (1 view) | 71010 | Hip Right | 73510 | CT Abd Pelvis Complete without and with IV contrast Standard Exam | 74178 |
| Chest Pa and Lat | 71020 | Hip Left | 73510 | | |
| Ribs Left | 71101 | Femur Right | 73550 | CT Abd Pelvis Complete without IV contrast If Iodine Allergy | 74176 |
| Ribs Right | 71101 | Femur Left | 73550 | | |
| Other: | | Knee Right | 73562 | CT Upper Abd only w/o and w IV contrast | 74170 |
| | | Knee Left | 73562 | CT Pelvis with IV contrast | 72193 |
| KUB | 74000 | Tibula/Fibula Right | 73590 | CT Head / Brain without and with IV contrast | 70470 |
| Acute Abd Series | 74022 | Tibula/Fibula Left | 73590 | CT Head / Brain without IV contrast | 70450 |
| Other: | | Ankle Right | 73610 | CT Orbit/Ear/Sella no contrast | 70480 |
| | | Ankle Left | 73610 | CT Sinus complete no IV contrast | 70486 |
| Cervical Spine | 72050 | Foot Right | 73630 | CT Chest with IV contrast | 71260 |
| Thoracic Spine | 72072 | Foot Left | 73630 | Other: | |
| Lumbar Spine | 72110 | Toe Right 1 2 3 4 5 | 73660 | | |
| Scoliosis Series | 72010 | Toe Left 1 2 3 4 5 | 73660 | Ultrasound | |
| Sacrum/Coccyx | 72220 | Other: | | Abdomen Complete | 76700 |
| Other: | | | | Abdomen Limited for GB etc. | 76705 |
| | | | | Pelvis Complete | 76856 + |
| | | | | PelvisTransVaginal if required | 76830 |
| Head | | Fluoroscopy/IVP | | OB complete < 14weeks | 76801 |
| Skull | 70260 | Barium Swallow | 74220 | OB complete > 14weeks | 76805 |
| Sinus Series | 70220 | Barium Swallow Speech Therapy | 74230 | OB Trans Vaginal <input type="checkbox"/> if required | 76817 |
| SinusUpright Waters | 70210 | UGI with air | 74247 | OB Follow up | 76816 |
| Facial Bones | 70150 | Small Bowel Series | 74250 | OB Bio Physical Profile | 76819 |
| Other: | | Barium Enema / Mag Citrate Bisacodyl kit | 74270 | Kidney / Renal / Aorta complete | 76770 |
| | | IVP / Mag Citrate Bisacodyl kit | 74400 | US Breast L R | 76645 |
| Upper Extremity | | Patient purchase Laxative Prep Kit from pharmacy 1 btl Mag Citrate, 2 Bisacodyl, 1 Glycerine Suppository | | Other: | |
| Shoulder, Right | 73030 | | | Vascular | |
| Shoulder, Left | 73030 | | | Carotid Duplex Bilateral | 93880 |
| Humerus, Right | 73060 | Nuclear Medicine | | Venous Duplex Unilateral <input type="checkbox"/> Right <input type="checkbox"/> Left | 93971 |
| Humerus, Left | 73060 | Bone Scan | 78306 | Venous Duplex Bialteral | 93970 |
| Elbow, Right | 73080 | Cardiac Stress Test | 78452 | Peripheral Arterial Doppler Segmental Study | 93923 |
| Elbow, Left | 73080 | Lung Scan | 78587 | Ankle Brachial Index only | 93922 |
| Forearm, Right | 73090 | HIDA Scan | 78223 | Cardio-Pulmonary | |
| Forearm, Left | 73090 | Thyroid Scan | 78006 | Echocardiogram | 93306 |
| Wrist, Right | 73110 | Other: | | Electroencephalogram (EEG) | 95819 |
| Wrist, Left | 73110 | | | Holter Monitor | 93225 + |
| Hand, Right | 73130 | MRI / MRA | | 2 CPT codes | 93226 |
| Hand, Left | 73130 | Brain <input type="checkbox"/> w/o and with contrast | 70553 | Cardiac Event Monitor | 93270 |
| Finger, Right 1 2 3 4 5 | 73140 | Cervical <input type="checkbox"/> w/o contrast | 72141 | Arterial Blood Gas (ABG) | |
| Finger, Right 1 2 3 4 5 | 73140 | Lumbar <input type="checkbox"/> w/o contrast | 72148 | Pulmonary Function Test (PFT) | 94010 |
| Other: | | Thoracic <input type="checkbox"/> w/o contrast | 72146 | Other: | |
| Mammography / Bone Density | | Orbit/ IAC w/o contrast | 70540 | | |
| Screening | G0202 | Lower Ext Joint without contrast | 73721 | | |
| Diagnostic unilateral | G0206 | Lower Ext non joint without contrast | 73718 | Comments / list current medications | |
| Diagnostic bilateral | G0204 | MRA Head & Neck without contrast | 70544 | | |
| Breast US if required | 76645 | Other: | | | |
| BMD / DEXA | 77080 | <input type="checkbox"/> w/o <input type="checkbox"/> with contrast | | | |

Diagnosis and ICD9:

Physician Signature and Printed Name

Date

Dear Patient: Thank you for choosing Clarendon Memorial Hospital. We are here for you.

You have the option to pre register over the phone. Please call (803)-435-3121 and ask for Registration. Be prepared to give your current address, phone number, employer and insurance information.

Upon your arrival to Clarendon Memorial Hospital, please report to the Outpatient Registration area and sign in.