



RADIOLOGY IMAGING REQUEST FORM

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Cherry Creek Medical Center Fax: 720-516-9448

Broomfield Radiology Fax: 303-544-3835

North Region Fax: 970-495-7671 / South Region Fax :719-365-5845

Email: UCH-RadiologyOrderingProviderSupport@uchealth.org

IN ADDITION TO THIS FORM: Documents supporting medical necessity is *REQUIRED*. This may include current progress notes, imaging reports, and/or other relevant documentation. Send this documentation via your preferred method (above). If supporting documentation is not received, authorization may not be obtained, resulting in delay of treatment.

Patient Information:

Patient Name:		Date of Birth:	Gender/Sex:
Address:	City, State:	Zip Code:	Phone Number:

Insurance Information:

Insurance Provider:	Member/Provider Services Phone Number:
Member ID:	Group ID:

Imaging Order:

<input type="checkbox"/> CT	<input type="checkbox"/> MR	<input type="checkbox"/> Nuclear Medicine	<input type="checkbox"/> PET/CT Scan
<input type="checkbox"/> XRAY/Fluoro	<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Other	
Procedure/Exam/CPT Code:	<input type="checkbox"/> W/O Contrast <input type="checkbox"/> With Contrast <input type="checkbox"/> W/WO Contrast <input type="checkbox"/> Allergy to contrast	Laterality: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral	
Diagnosis Codes:			
Signs, Symptoms and Clinical Suspicion:			

Is the patient claustrophobic? ☐ YES or ☐ NO

☐ Oral Sedative (Medication given by referring provider) ☐ IV Sedation by RAD RN's (North Region ONLY)
☐ General Anesthesia

☐ Perform as ordered, DO NOT ALTER ☐ Okay to be altered per Radiologist Discretion (Default)

REQUIRED FOR MEDICARE PATIENTS:

Appropriate Use Criteria (AUC)/Clinical Decision Support (CDS) Documentation

Session ID:_____ Score:_____ Vendor:_____ Adherence:_____

Referring Provider Information:

Last/First Name(Print, must be legible):	NPI:
Provider Direct Cell/Pager Number:	Direct Office Contact Person/Number: (If provider not available):
Provider Signature:	Date:

**Information submitted will be transmitted securely to the appropriate UCHealth imaging facility:
Select One Below**

☐ Metro Denver ☐ North Region ☐ South Region ☐ Boulder Sports Med

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