# RADIOLOGY IMAGING REQUEST FORM

**Email: RadiologyOrders@uchealth.org**
**Voicemail: 720-848-9396**
**REGIONAL FAX NUMBERS**

**North Radiology: 970-495-7671; Breast Imaging: 970-207-4755**
**Metro Radiology: 720-848-1651; Breast Imaging: 720-848-1650**
**CO Springs Radiology: 719-365-5845;Breast Imaging: 719-364-3626**
**Parkview-Pueblo, CO Radiology and Breast Imaging: 719-595-7679**

**IN ADDITION TO THIS FORM: Documents supporting medical necessity are *REQUIRED*. This may include current progress notes, imaging reports, and/or other relevant documentation. Send this documentation via your preferred method (above). Patients will not be allowed to schedule until all documentation is received; which may result in delay of treatment. Please allow 2 business days for processing and then have patients call 844-RAD-APPT to schedule.**

## 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:

| ☐ CT | ☐ MR | ☐ Nuclear Medicine | ☐ PET/CT Scan |
|---|---|---|---|
| ☐ XRAY/Fluoro | ☐ Ultrasound | ☐ Other | |

| Procedure/Exam/CPT Code: | ☐ W/O Contrast<br>☐ With Contrast<br>☐ W/WO Contrast<br>☐ Allergy to contrast | Laterality:<br>☐ Left<br>☐ Right<br>☐ Bilateral |
|---|---|---|
| Diagnosis Codes: | | |

Signs, Symptoms and Clinical Suspicion:

**Is the patient claustrophobic?** ☐ YES or ☐ NO

☐ Oral Sedation (Medication given by referring provider) ☐ General Anesthesia ☐ Anxiolysis (North Region ONLY)

☐ 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**

☐ **North Region (Longmont-Fort Collins)** ☐ **Metro Denver Region** ☐ **CO Springs Region** ☐ **Parkview- Pueblo**