Fax to (928) 283-1447   Total Pages:________

TCRHCC Patient Label/Stamp

Tuba City
Regional Healthcare Corporation

Primary Imaging Order Form (page 1 of 2)

Please see our website: http://tchealth.org/imaging_study/ for Secondary Order Forms, Patient Instructions, and other items to submit.

CT	CONTRAST With	Without	Combined
☐ Abdomen	74150	74160	74170
☐ Abd/Pelvis (combined)	74176	74177	74178
☐ Brain	70450	70460	70470
☐ Cervical Spine	72125	72126	72127
☐ Chest	71250	71260	71270
☐ Chest High Resolution	N/A	71250	N/A
☐ Lower Extremity [L / R]	73700	73701	73702
☐ Lumbar Spine	72131	72132	72133
☐ Orbits/Temporal Bone	70480	70481	70482
☐ Pelvis	72192	72193	72194
☐ Sinuses/Maxillofacial	70486	70487	70488
☐ Shoulder [L / R]	N/A	73200	N/A
☐ Soft Tissue Neck	70490	70491	70492
☐ Thoracic Spine	72128	72129	72130
☐ Triple Phase Liver	74160	N/A	N/A
☐ Triple Phase Pancreas	74160	N/A	N/A
☐ Triple Phase Renal	74177	N/A	N/A
☐ Upper Extremity [L / R]	73200	73201	73202
☐ Urogram	74178	76377	N/A

MRI	CONTRAST With	Without	Combined
☐ Abdomen	N/A	74182	74183
☐ Brachial Plexus	N/A	70540	70543
☐ Brain	N/A	70552	70553
☐ Breast, Bilateral	N/A	N/A	77059
☐ C-Spine	N/A	72142	72156
☐ Internal Auditory Canal	N/A	70551	70553
☐ Lower Extremity:	N/A	73719	73720
☐ Lower Extremity Joint:	N/A	73722	73723
☐ Lumbar Spine	N/A	72149	72158
☐ *MRCP*	N/A	N/A	74183 76377
☐ Neck Soft Tissue	N/A	70540	70543
☐ Orbits	N/A	70542	70543
☐ Pelvis	N/A	72195	72197
☐ Seizure, new onset	N/A	N/A	70553
☐ Seizure, follow-up	N/A	70551	N/A
☐ SI Joints/Pelvis	N/A	72195	72197
☐ Thoracic Spine	N/A	72147	72157
☐ TMJ Joint	N/A	N/A	N/A

MRI continued	CONTRAST With	Without	Combined
☐ Upper Extremity:	N/A	73219	73220
☐ Upper Extremity Joint:	N/A	73222	73223

CTA	CONTRAST With	Without	Combined
☐ Abdomen	74175	N/A	N/A
☐ Abdomen aorta & Bilateral Runoff	75635	N/A	N/A
☐ Chest (PE Study)	71275	N/A	N/A
☐ Chest (aorta)	75574	N/A	N/A
☐ Head	70496	N/A	N/A
☐ Lower Extremity [L / R] ☐ with runoff	73706	N/A	N/A
☐ Neck	70498	N/A	N/A
☐ Pelvis	72191	N/A	N/A
☐ Upper Extremity [L / R]	73206	N/A	N/A

MRA / MRV	CONTRAST With	Without	Combined
☐ Carotids & Neck MRA	N/A	70547	70549
☐ Head MRA Circle of Willis	N/A	70545	N/A
☐ Head MRV	N/A	70544	N/A

☐ **Comments or OTHER CT / CTA / MRI / MRA / MRV:**

Check/Complete all that apply (*complete for contrast studies only, #complete for procedures only):

☐Y ☐N Patient is pregnant. If yes , number of weeks gestation:______________

☐Y ☐N *Previous contrast allergy, contrast type:____

☐Y ☐N *Patient has diabetes or renal disease . If yes , include Creatinine and GFR levels in the past 30 days:

Creatinine:________, date:_______ GFR:________, date:_______

☐Y ☐N *Patient on hemodialysis. If yes,
Dialysis days:__________________________________ Dialysis Facility_____________________________________
K+ (past 30 days)_________, date:________

☐Y ☐N #Patient is having a lung, liver, or kidney biopsy and/or has a bleeding disorder (circle all that apply).
If yes, include PT/PTT level (within past 30 days):__________________, date:____________

☐Y ☐N #Patient is taking anticoagulants, If yes, list:

____

☐Y ☐N #Patient is allergic to medications. If yes, list:

____

☐Y ☐N Patient is scheduled for other procedures the same day of imaging study. If yes, list:

____

Primary Imaging Order Form (page 2 of 2)

Please see our website: http://tchealth.org/imaging_study/ for Secondary Order Forms, Patient Instructions, and other items to submit

Fluoroscopy (Arthrogram & GI Studies)	CPT Codes
Arthrogram:	
☐ Ankle [L / R]	73615
☐ Elbow [L / R]	73085
☐ Hip [L / R]	73525
☐ Knee [L / R]	73722
☐ Shoulder [L / R]	73040
☐ Wrist [L / R]	73115
☐ Barium Enema Colon (fasting)	74280
☐ Barium Enema Colon w/o Air = limited (fasting)	74270
☐ Barium Enema Therapy RED Intussusception (fasting)	74283
☐ Barium Swallow	74220
☐ Modified	74230
☐ Cholangiogram T-tube	74305, 47505
☐ Hysterosalpingogram	74740
☐ Small Bowel Follow Through (fasting)	74250
☐ Upper GI w/Air = "double contrast" (fasting)	74247
☐ Upper GI Small Bowel Follow Through (fasting)	74249
☐ Voiding Cysto-Urethrogram (VCUG)	74455

Mammography, Breast Ultrasound, & Breast Biopsy	CPT Codes	L	R
☐ Mammography Screening	G0202	N/A	N/A
☐ Mammography Bilateral Diagnostic	G0204	N/A	N/A
☐ Mammography Unilateral Diagnostic	G0206		
☐ Breast Core Biopsy	19102 19103		
☐ Breast Cyst Aspiration	19000		
☐ Breast Cyst Aspiration add'l	19001		
☐ Breast Ultrasound (if indicated)	76645		
☐ Stereotactic Guidance	19081		
☐ U/S guidance for needle placement	19083		

Echocardiogram	CPT Codes
☐ Echocardiogram Adult	99306
☐ Echocardiogram Pediatric	99303

Ultrasound General	CPT Codes
☐ Abdomen complete	76700
☐ Abdomen limited	76705
☐ Extremity for palpable abnormality please describe	76882
☐ Kidney/Aorta	76770
☐ Kidney/Bladder	76770 76856
☐ Transplanted Kidney, duplex doppler	76776
☐ Pelvis	76856
☐ Scrotum	76870 93975
☐ Thyroid	76536
☐ Transvaginal Pelvis	76830

Bone Density Screening (DEXA)	CPT Codes
☐ Appendicular	77081
☐ Axial	77080

Xray

☐ see completed "Xray Order Form"

Ultrasound Vascular	CPT Codes	L	R
☐ Venous Extremity Unilateral r/o DVT	93971		
☐ Venous Extremity Bilateral r/o DVT	93975		
☐ Abdomen Doppler complete	93975		
☐ Abdomen Doppler limited	93976		
☐ Arterial Extremity Bilateral	93925		
☐ Arterial Extremity Unilateral	93926		
☐ Carotid Artery Bilateral	93880		
☐ Kidney/Aorta	76770		
☐ Kidney w/Aorta, kidney transplant	76770 93976		
☐ Transplanted Kidney, duplex doppler	76776		
☐ Reflux study, lower extremity (venous insufficiency)	93971		

Other Interventional Radiology:

☐ see completed "IR Order Form"

Hemodialysis Access Maintenance

☐ Fistulagram / Graftogram	**Access Site:** ☐ L ☐ R ☐ UE ☐ LE	**Dialysis Center:**
☐ Catheter Placement / Removal / Exchange	**Recent Flow Rate (cc/min):**	**Nephrologist:**
☐ OTHER:	**Reason/Problem:**	

Comments/Other:

Patient Name:____ DOB:______________ ☐Male ☐Female

Ht:__________Wt.:___________ Verified Pt. Phone #/Contact:____

Caregiver/Facility Name/Phone:____

PCP/Facility:____

Insurance: ☐Medicaid ☐Medicare __________ ☐ IHS beneficiary ☐Private: ________________________ ☐None

Please allow a minimum of one week for insurance pre-authorization, if possible.

Referring Provider Name/Credentials/Facility/Dept:____

If not on record: NPI#:___________________________State License #:________________State:_____________

Phone (urgent/critical results):__________________________Fax (routine results):_________________________

Diagnosis:____ICD 9 Code:________________________

Study/Procedure Urgency: ☐ Routine ☐ Urgent (1-14 days) ☐ ASAP

A COMPLETE ORDER IS REQUIRED AT THE TIME OF SCHEDULING (check all that are included/applicable):

☐ Relevant Imaging ☐ Clinical Notes ☐ Health Summary ☐ Current Medications List

☐ Secondary Order Forms ☐ Lab Results ☐ Insurance Card ☐ I have reviewed/distributed patient instructions

HCG will be given upon arrival for women ages 12-52.

Office Use Only: