

Name: _____ (Last, First, Middle Initial) DOB: _____ MRN: _____

Patient Contact Number: _____ Physician Fax Number: _____

Note: Creatinine and/or pregnancy testing will be performed per protocol

Decision Support #: _____

Scoring 0-9: _____

Vendor: _____

Diagnosis / Signs and Symptoms
(please fill out a separate form for each modality):

Reason for exam: _____
*(required)

ICD 10: _____
*(required)

Patient Safety

Contrast Allergy: Y N

(Reaction) _____

Other Allergies: _____

Interpreter needed: Y N

Insurance Authorization
Number (required): _____

Code specificity may require laterality, anatomical location, healing status (routine, delayed), fracture type (open, closed), acuity, trimester (obstetrics), malignancy site (primary, secondary), or other particular details.

X-Ray		Left	Right	Left	Right
<input type="checkbox"/> Chest	<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Clavicle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pelvis	<input type="checkbox"/> Humerus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Orbits (foreign body) with the CPT, 70030	<input type="checkbox"/> Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> Forearm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/> Wrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Scoliosis				<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other (List Exam here): _____					

Fluoroscopy		
<input type="checkbox"/> Esophagram	<input type="checkbox"/> Barium Enema without Air	<input type="checkbox"/> UGI Small Bowel
<input type="checkbox"/> Modified Barium Swallow with SP	<input type="checkbox"/> Small Bowel	<input type="checkbox"/> VCUG
<input type="checkbox"/> Barium Enema	<input type="checkbox"/> Upper GI with Air	<input type="checkbox"/> Hysterosalpingogram
<input type="checkbox"/> Other (List exam here): _____		

Breast Imaging/Mammography	Left	Right
Screening Mammography <input type="checkbox"/> Bilateral <input type="checkbox"/> Unilateral	<input type="checkbox"/>	<input type="checkbox"/>
Diagnostic Mammography <input type="checkbox"/> Bilateral <input type="checkbox"/> Unilateral	<input type="checkbox"/>	<input type="checkbox"/>
Ultrasound Breast <input type="checkbox"/> Bilateral <input type="checkbox"/> Unilateral	<input type="checkbox"/>	<input type="checkbox"/>
Stereotactic biopsy <input type="checkbox"/> Bilateral <input type="checkbox"/> Unilateral	<input type="checkbox"/>	<input type="checkbox"/>
Ultrasound guided biopsy <input type="checkbox"/> Bilateral <input type="checkbox"/> Unilateral	<input type="checkbox"/>	<input type="checkbox"/>
MRI Breast <input type="checkbox"/> Contrast <input type="checkbox"/> Implant evaluation		
<input type="checkbox"/> Other (List exam here): _____		
<input type="checkbox"/> Diagnostic mammogram, ultrasound, stereotactic biopsy, US guided biopsy/lymph node biopsy or cyst aspiration as indicated by the Radiologist		

Bone Density	CPT Code
Dexa: Axial Skeleton	77080
Dexa: Appendicular	77081
Site: _____	

Ultrasound	
Abdomen: <input type="checkbox"/> Complete <input type="checkbox"/> Limited <input type="checkbox"/> Doppler	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Pregnancy (List Exam here): _____	<input type="checkbox"/> Bladder
<input type="checkbox"/> Vascular (List Exam here): _____	<input type="checkbox"/> Kidney
<input type="checkbox"/> Extremity for Abnormality: _____	<input type="checkbox"/> Aorta
	<input type="checkbox"/> Pelvis
<input type="checkbox"/> Other (List Exam here): _____	<input type="checkbox"/> Scrotum and Contents
	<input type="checkbox"/> Transvaginal
<input type="checkbox"/> Doppler as clinically indicated by Radiologist. Preauthorization Required if Applicable.	<input type="checkbox"/> Transrectal
	<input type="checkbox"/> Carotid Artery Bilateral
	<input type="checkbox"/> Neonatal Head

Telephone number where we can contact you with critical results: _____

CT	CONTRAST		
	Without	With	W/WO
Brain/Head	<input type="checkbox"/> 70450	<input type="checkbox"/> 70460	<input type="checkbox"/> 70470
<input type="checkbox"/> Facial <input type="checkbox"/> Sinuses	<input type="checkbox"/> 70486	<input type="checkbox"/> 70487	
Orbits	<input type="checkbox"/> 70480	<input type="checkbox"/> 70481	
Temporal Bone	<input type="checkbox"/> 70480	<input type="checkbox"/> 70481	
Soft Tissue Neck	<input type="checkbox"/> 70490	<input type="checkbox"/> 70491	
Chest	<input type="checkbox"/> 71250	<input type="checkbox"/> 71260	
CTA Chest PE	<input type="checkbox"/> 71275		
Lung cancer screening CT <input type="checkbox"/> Initial <input type="checkbox"/> Annual	<input type="checkbox"/> 71250		
High resolution chest CT (ILD)	<input type="checkbox"/> 71250		
Abdomen	<input type="checkbox"/> 74150	<input type="checkbox"/> 74160	<input type="checkbox"/> 74170
Pelvis	<input type="checkbox"/> 72192	<input type="checkbox"/> 72193	
CT abdomen and pelvis	<input type="checkbox"/> 74176	<input type="checkbox"/> 74177	
CT urogram			<input type="checkbox"/> 74178
Upper Extremity: <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> 73200	<input type="checkbox"/> 73201	<input type="checkbox"/> 73202
Lower Extremity: <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> 73700	<input type="checkbox"/> 73701	<input type="checkbox"/> 73702
Cervical Spine	<input type="checkbox"/> 72125	<input type="checkbox"/> 72126	<input type="checkbox"/> 72127
Thoracic Spine	<input type="checkbox"/> 72128	<input type="checkbox"/> 72129	<input type="checkbox"/> 72130
Lumbar Spine	<input type="checkbox"/> 72131	<input type="checkbox"/> 72132	<input type="checkbox"/> 72133
CT Angiography			
Head			<input type="checkbox"/> 70496
Neck			<input type="checkbox"/> 70498
CTA Chest PE			<input type="checkbox"/> 71275
Abdomen Aorta & Bilateral Runoff			<input type="checkbox"/> 75635
Coronary			<input type="checkbox"/> 75574
Upper Extremity: <input type="checkbox"/> Right <input type="checkbox"/> Left			<input type="checkbox"/> 73206
Lower Extremity: <input type="checkbox"/> Right <input type="checkbox"/> Left			<input type="checkbox"/> 73706
<input type="checkbox"/> Other CT Exam (List Exam here): _____			

MRI	CONTRAST	
	Without	W/WO
<input type="checkbox"/> Brain <input type="checkbox"/> Pituitary <input type="checkbox"/> IAC	<input type="checkbox"/> 70551	<input type="checkbox"/> 70553
<input type="checkbox"/> Orbits <input type="checkbox"/> Facial <input type="checkbox"/> Neck	<input type="checkbox"/> 70540	<input type="checkbox"/> 70543
Chest	<input type="checkbox"/> 71550	<input type="checkbox"/> 71552
Abdomen	<input type="checkbox"/> 74181	<input type="checkbox"/> 74183
Pelvis	<input type="checkbox"/> 72195	<input type="checkbox"/> 72197
Sacrum	<input type="checkbox"/> 72195	<input type="checkbox"/> 72197
MRCP	<input type="checkbox"/> 74181	<input type="checkbox"/> 74183
Cervical Spine	<input type="checkbox"/> 72141	<input type="checkbox"/> 72156
Thoracic Spine	<input type="checkbox"/> 72146	<input type="checkbox"/> 72157
Lumbar Spine	<input type="checkbox"/> 72148	<input type="checkbox"/> 72158
Heart w/o Contrast ----- 75557		
HEART w/o Contrast w Stress ----- 75559		
HEART w/o and w Contrast ----- 75561		
HEART w/o and w Contrast w Stress ----- 75563		
Velocity Flow Y/N +75565		
Upper Extremity: <input type="checkbox"/> Right <input type="checkbox"/> Joint <input type="checkbox"/> Left <input type="checkbox"/> Non-Joint	<input type="checkbox"/> 73221	<input type="checkbox"/> 73223
Lower Extremity: <input type="checkbox"/> Right <input type="checkbox"/> Joint <input type="checkbox"/> Left <input type="checkbox"/> Non-Joint	<input type="checkbox"/> 73721	<input type="checkbox"/> 73723
MRI - Arthrogram: <input type="checkbox"/> Right <input type="checkbox"/> Left		
Site _____		
MRI Angiography		
Head	<input type="checkbox"/> 70544	<input type="checkbox"/> 70546
Neck	<input type="checkbox"/> 70547	<input type="checkbox"/> 70549
Chest	<input type="checkbox"/> 71555	<input type="checkbox"/> 71557
Abdomen	<input type="checkbox"/> 74185	<input type="checkbox"/> 74187
<input type="checkbox"/> Other MRI or MRA Exam (List Exam here): _____		



Department of Radiology & Biomedical Imaging

NEW HAVEN

Yale New Haven Hospital
20 York Street
New Haven, CT 06510

- Smilow Cancer Hospital, North Pavilion, Fl. 2

MRI Center
801 Howard Avenue
New Haven, CT 06510

Yale Physician's Building *
800 Howard Avenue, Fl. 1
New Haven, CT 06510

St. Raphael Campus
1450 Chapel Street
New Haven, CT 06511

1 Long Wharf Drive, Fl. 2 (Pediatric only)
New Haven, CT 06511

150 Sargent Drive, Fl. 1 *
New Haven, CT 06511

EAST HAVEN

556 Main Street *
East Haven, CT 06512

GUILFORD

Shoreline Medical Center *
111 Goose Lane
Guilford, CT 06437

HAMDEN

2560 Dixwell Avenue, Fl. 1 *
Hamden, CT 06518

NORTH HAVEN

6 Devine Street, Fl. 1 *
North Haven, CT 06473

NORWALK

Pediatric Specialty Center * (Pediatric only)
747 Belden Avenue, Fl. 2
Norwalk, CT 06850

OLD SAYBROOK

Old Saybrook Medical Center
633 Middlesex Turnpike *
Old Saybrook, CT 06475

WEST HAVEN

500 Elm Street *
West Haven, CT 06516

* Blood draw available at select locations.

Radiology services vary at each location.