Vanderbilt Health
Department of Radiology & Radiological Sciences
Diagnostic Imaging Order Form
Orders - *Radiology*

Patient Label or Patient Identifiers

All exam types except plain film x-rays must be scheduled in advance by calling:

- Vanderbilt University Medical Center (VUH): (615) 343-2617 and faxing order to (615) 322-0793
- Vanderbilt Wilson County Hospital (VWCH): (615) 449-8621 and faxing order to (615) 453-8234.
- Vanderbilt Tullahoma-Harton Hospital (VTHH): (931) 461-4800 and faxing order to (931) 461-4900.
- Vanderbilt Bedford Hospital (VBCH): (931) 685-8305 and faxing order to (931) 685-8306.

Please note, the Vanderbilt Department of Radiology does not perform imaging with conscious sedation or anesthesia referred by non-VUMC referring providers.

Appointments cannot be scheduled until an order is received.

Patient Name: _____ **Patient Date of Birth:** _____

Sex: ☐ Male ☐ Female **Last four Digits of SSN:** _____

Type of Exam (Please include contrast specifications and area of concern): _____

_____

Reason for Procedure: _____

Associated ICD 10 Diagnosis Code: _____ **Expected/Preferred Date of Exam:** _____

Priority: ☐ Routine ☐ STAT (honored for emergent diagnoses only)

Does the patient have a pacemaker or any implanted device? ☐ Yes ☐ No If yes, Make: _____ Model: _____

Please also, fax documentation of make and model and instruct the patient to bring documentation on the day of service.
Please note, pacemaker and cardiologist information is required for scheduling.

Cardiologist name: _____ Phone: _____ Fax: _____

Is the patient pregnant? ☐ Yes ☐ No **Is the patient breastfeeding?** ☐ Yes ☐ No

Is the patient allergic to iodinated contrast media?..... ☐ Yes ☐ No

If yes, is there a severe reaction?..... ☐ Yes ☐ No

If yes, please explain severe reaction: _____

PAMA Consult Confirmation for MRI & CT & Nuclear Medicine/PET ONLY; Traditional Medicare Patients ONLY:
Complete below or PREFERABLY send a copy of Consultation Confirmation from the CDSM for exam.

Decision Support # _____	Decision Support # _____	Decision Support # _____
Service Type _____	Service Type _____	Service Type _____
Appropriate Score _____	Appropriate Score _____	Appropriate Score _____
HCPCS-G Code (Vender Code) _____	HCPCS-G Code (Vender Code) _____	HCPCS-G Code (Vender Code) _____
HCPCS Modifier _____	HCPCS Modifier _____	HCPCS Modifier _____

Ordering: I have reviewed and confirmed this information with the Patient/Legal Representative.

Provider Print Name: _____ Title: _____

Provider Signature: _____ Date: _____ Time: _____

Pager or Cell Phone: _____ Office Phone: _____ Office Fax: _____

Pre-certification/Insurance Authorization (if required): _____