VANDERBILT UNIVERSITY
MEDICAL CENTER

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

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.**

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, fax documentation of make and model to (615) 322-0793 (VUH) or (615) 453-8234 (VWCH), and instruct the patient to bring documentation on the day of service

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): _____