

Patient Label

# CT REFERRAL/ORDER FORM

Room number/bed \_\_\_\_\_  
Vent Y or N  
Precautions Y or N

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Patient's weight: \_\_\_\_\_

Date CT Scheduled: \_\_\_\_\_ MRN #: \_\_\_\_\_ Ordering Physician: \_\_\_\_\_

Reason for Exam: \_\_\_\_\_ **Physician's signature:** \_\_\_\_\_

**TYPE OF CT DESIRED**

**Date and Time** \_\_\_\_\_

- \_\_\_ Brain without contrast 70450      **CTA**
- \_\_\_ Brain with contrast 70460      \_\_\_ **CTA ABD** 74175
- \_\_\_ Brain with & without 70470      \_\_\_ **CTA Aortobifemoral** 75635
- \_\_\_ Chest without (standard) 71250      \_\_\_ **CTA Brain** 70496
- \_\_\_ Chest with (P.E.) 7126      \_\_\_ **CTA Carotids** 70498
- \_\_\_ Chest with (standard) 71260      \_\_\_ CTA Chest 71275
- \_\_\_ Chest without (high res) 71250      \_\_\_ CTA Coronary 0146T
- \_\_\_ Spine cervical 72125
- \_\_\_ Spine thoracic 72128
- \_\_\_ Spine lumbar 72131
- \_\_\_ Abdomen without & with 74170      \_\_\_ Pelvis without & with 72194
- \_\_\_ Abdomen without 74150      \_\_\_ Pelvis without 74150
- \_\_\_ Abdomen with contrast 74160      \_\_\_ Pelvis with contrast 72193
- Hematuria protocol
- \_\_\_ CT abdomen with & without 74170      \_\_\_ CT Pelvis 72194      \_\_\_ KUB 74000
- \_\_\_ Neck with (soft tissue) 70491
- \_\_\_ Facial bones without (sinuses) 70486
- \_\_\_ Facial bones without (bones) 70486
- \_\_\_ Orbits with contrast 70481
- \_\_\_ Petrous, sella orbits without 70480
- \_\_\_ High res temporal bone 70480
- \_\_\_ extremity lower without 73700
- \_\_\_ extremity upper without 73200
- \_\_\_ CT guided biopsy 77012
- \_\_\_ CT guided placement rad fields 77014 specify location \_\_\_\_\_

Does the patient have difficulty laying flat on back? \_\_\_

**\* If patient is being scheduled for an exam with IV contrast and is taking Glucophage, Metformin, Glucovanc, Metaglip, or Avandamet, patient must hold medication for at least 48 hours post exam. Patient will require a stable BUN and Creatinine prior to restarting the above medications.**

Allergy history: \_\_\_\_\_

Is patient allergic to the x-ray dye? YES  NO

If YES, please explain: \_\_\_\_\_

Pregnant? YES  NO  Diabetic? YES  NO

**\* Glucophage, Metformin, Glucovance, Metaglip, Avandamet? YES  NO**

Last dose? \_\_\_\_\_

Instructions given per Metformin policy       Patient verbalizes understanding

Prior pertinent surgery  
**IF PATIENT IS HAVING AN IV CONTRAST EXAM:**

BUN \_\_\_\_\_ CREATININE \_\_\_\_\_  
DATE \_\_\_\_\_

**Required for diabetics and patients over 60 yrs of age.**

Form completed by \_\_\_\_\_

Date/ Time \_\_\_\_\_