

Please call patient to schedule  Personal Injury or Medical Lien

**If STAT, please check**  
 Fax STAT  
 Call STAT Report, patient may leave  
 Phone # \_\_\_\_\_  
 Call STAT Report, patient waiting  
 Phone # \_\_\_\_\_

RR to obtain authorization  
 Clinical notes attached  
 ICD-10 code(s)  
 \_\_\_\_\_  
 CDS # \_\_\_\_\_

Patient's Name Last First MI Birthdate / /

Patient/Parent Phone Home Cell Work Email

Insurance (type) (Policy #) Group # (Authorization #)

Physician's Name (print) First Last Practice Name & Address Required Physician's Signature (No stamps allowed) Date

Exam requested Previous related studies? If so, where?

Reason for exams/symptoms Specific protocol needs  
 This order authorizes Raleigh Radiology to perform lab procedures on patients as deemed medically necessary.

Ultrasound	X-ray	Large Bore MRI/MRA
<input type="checkbox"/> Abdomen* <input type="checkbox"/> Aorta <input type="checkbox"/> Appendix* <input type="checkbox"/> Renal <input type="checkbox"/> RUQ (Liver/Gallbladder) <input type="checkbox"/> Testicular <input type="checkbox"/> with Doppler evaluation <input type="checkbox"/> Pelvis TA Only <input type="checkbox"/> Pelvis TVP <input type="checkbox"/> if indicated <input type="checkbox"/> TVP Only <input type="checkbox"/> Check if you want Doppler evaluation <input type="checkbox"/> Neonatal Head* <input type="checkbox"/> Neonatal Hips <input type="checkbox"/> Neonatal Spine* <input type="checkbox"/> Pyloric Stenosis <input type="checkbox"/> Thyroid <input type="checkbox"/> FNA <input type="checkbox"/> Cyst Aspiration <input type="checkbox"/> Breast (Blue Ridge & Cary) <input type="checkbox"/> Other _____ <input type="checkbox"/> HSS (LMP _____) <input type="checkbox"/> OB (EGA _____) <input type="checkbox"/> Abdominal Sonogram with liver elastography <input type="checkbox"/> Complete <input type="checkbox"/> Limited <input type="checkbox"/> Other _____	<p><b>Select if applicable:</b> <input type="checkbox"/> Left <input type="checkbox"/> Right</p> <input type="checkbox"/> Sinuses <input type="checkbox"/> Chest <input type="checkbox"/> Ribs <input type="checkbox"/> Pelvis <input type="checkbox"/> Abdomen KUB specify _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> OC <input type="checkbox"/> OT <input type="checkbox"/> OL <input type="checkbox"/> Extremity <p style="background-color: #003366; color: white; text-align: center;"><b>Fluoroscopy</b></p> <p><i>*Blue Ridge &amp; Cary</i></p> <input type="checkbox"/> Barium Swallow* <input type="checkbox"/> Upper GI* <input type="checkbox"/> Small Bowel* <input type="checkbox"/> Barium Enema* <input type="checkbox"/> IVP <input type="checkbox"/> HSG* (LMP _____) <p style="background-color: #003366; color: white; text-align: center;"><b>Therapeutic Joint Injection</b></p> <input type="checkbox"/> Joint Injection (Arthrogram - refer to specific section CT or MRI) specify _____ <input type="radio"/> Left <input type="radio"/> Right <input type="checkbox"/> CT Guided Epidural Steroid Injections Please circle level C T L S <input type="checkbox"/> Other _____ <p style="background-color: #003366; color: white; text-align: center;"><b>CT Lung Screening</b></p> <input type="checkbox"/> CT Lung Screening (Asymptomatic) <input type="checkbox"/> Pack/year history (20+): _____ <input type="checkbox"/> Referrer NPI: _____ <input type="checkbox"/> Age: 50-80 <input type="checkbox"/> Smoking Status: <input type="radio"/> Current <input type="radio"/> Former # of years since quitting _____ By signing this order, you certify you have completed the shared decision making process with the patient <p style="background-color: #003366; color: white; text-align: center;"><b>DEXA</b></p> <input type="checkbox"/> Bone Density <input type="checkbox"/> Full Body Scan Vertebral fracture assessment performed if indicated	<p><b>Select if applicable:</b></p> <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> w/Arthrogram <input type="checkbox"/> IV Contrast as medically indicated <input type="checkbox"/> w/o IV contrast <input type="checkbox"/> w & w/o IV contrast <input type="checkbox"/> w/ IV contrast <input type="checkbox"/> Open MRI (Knightdale) <input type="checkbox"/> Brain <input type="checkbox"/> Orbits/Face <input type="checkbox"/> Brain w/ IAC <input type="checkbox"/> TMJ <input type="checkbox"/> Neck (Soft tissue) <input type="checkbox"/> C-Spine <input type="checkbox"/> T-Spine <input type="checkbox"/> L-Spine <input type="checkbox"/> Breast MRI <input type="checkbox"/> Screening <input type="checkbox"/> Implant Integrity/Rupture <input type="checkbox"/> Staging <input type="checkbox"/> Abdomen <input type="checkbox"/> Enterography <input type="checkbox"/> Pelvis (soft tissue) <input type="checkbox"/> Prostate <input type="checkbox"/> MRCP <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Bony Pelvis <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> MRA Brain <input type="checkbox"/> MRA Neck <input type="checkbox"/> MRA Aorta <input type="checkbox"/> MRA Abdomen <input type="checkbox"/> MRA Run off <input type="checkbox"/> MRV <input type="checkbox"/> Whole Body Screening MRI <input type="checkbox"/> Other _____
Vascular Ultrasound	CT/CTA	Breast Imaging
<p>Arterial Duplex will be performed w ABI as medically indicated</p> <p><b>Select if applicable:</b> <input type="checkbox"/> Left <input type="checkbox"/> Right</p> <input type="checkbox"/> Venous Duplex (Legs/Arms) <input type="checkbox"/> Venous Reflux (Legs) <input type="checkbox"/> Arterial Duplex (bilateral legs) <input type="checkbox"/> Arterial Duplex (Arms) <input type="checkbox"/> ABI <input type="checkbox"/> Other _____ <input type="checkbox"/> Arterial Aorta <input type="checkbox"/> Carotid Duplex <input type="checkbox"/> Renal arteries <input type="checkbox"/> Hepatic/Portal Duplex <input type="checkbox"/> SMA/Celiac Duplex	<p><b>Please include CREATININE levels and dates for all patients with acute or chronic renal failure, hx of kidney transplant. Lab work is current within 3 months.</b> Creatinine _____ Draw Date _____</p> <p><input type="checkbox"/> Contrast as medically indicated  <input type="checkbox"/> w/o contrast <input type="checkbox"/> w/contrast <input type="checkbox"/> w &amp; w/o contrast</p> <input type="checkbox"/> Brain <input type="checkbox"/> Facial Bones <input type="checkbox"/> Orbits <input type="checkbox"/> Sinus <input type="checkbox"/> CT Sinus for Intraoperative Guidance Specify protocol _____ <input type="checkbox"/> Neck soft tissue <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Abdomen & Pelvis <input type="checkbox"/> CT Calcium Scoring <input type="checkbox"/> Pelvis <input type="checkbox"/> Enterography <input type="checkbox"/> Renal Stone <input type="checkbox"/> Urogram <input type="checkbox"/> C-spine <input type="checkbox"/> T-spine <input type="checkbox"/> L-spine <input type="checkbox"/> Extremity <input type="radio"/> 3D <input type="radio"/> Left <input type="radio"/> Right Specify _____ <input type="checkbox"/> CTA Head <input type="checkbox"/> CTA Neck <input type="checkbox"/> CTA Chest <input type="checkbox"/> Aneurysm <input type="checkbox"/> Pulmonary Embolism <input type="checkbox"/> CTA Abdomen & Pelvis <input type="checkbox"/> Pre-stent <input type="checkbox"/> Post-stent <input type="checkbox"/> CTA Runoff (aortic bifurcation to ankles) <input type="checkbox"/> CTA Abdomen w/ runoff (diaphragm to ankles) (Abdominal w/lower Ext, bilateral) <input type="checkbox"/> CT Arthrogram <input type="radio"/> Left <input type="radio"/> Right Joint _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> Screening Mammo <input type="checkbox"/> 2D <input type="checkbox"/> 3D <input type="checkbox"/> Add views and/or US if medically needed <input type="checkbox"/> FAST Breast MRI Screening <input type="checkbox"/> Bilateral Diagnostic w/US if medically indicated <input type="checkbox"/> Unilateral Diagnostic w/US if medically indicated <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Breast Biopsy <input type="checkbox"/> Stereotactic <input type="checkbox"/> Ultrasound Guided <input type="checkbox"/> Breast Ultrasound <input type="checkbox"/> Left <input type="checkbox"/> Right Area _____ (with mammogram if medically indicated)
Nuclear Medicine (Blue Ridge)	Interventional Procedures (Midtown)	
<input type="checkbox"/> Thyroid Uptake & Scan <input type="checkbox"/> Thyroid Scan <input type="checkbox"/> Thyroid Therapy I-131 <input type="checkbox"/> Thyroid Carcinoma <input type="checkbox"/> Metastasis Whole Body Scan <input type="checkbox"/> Parathyroid Scan <input type="checkbox"/> HIDA Scan Only <input type="checkbox"/> HIDA Scan with CCK <input type="checkbox"/> Gastric Emptying <input type="checkbox"/> Rest MUGA <input type="checkbox"/> Bone Scan (whole body) <input type="checkbox"/> Bone Scan (limited bone scan) Site: _____ <input type="checkbox"/> Bone Scan 3 Phase <input type="checkbox"/> Renogram <input type="checkbox"/> Renogram with Lasix <input type="checkbox"/> Meckels Scan <input type="checkbox"/> Liver Spleen Scan <input type="checkbox"/> Breast <input type="checkbox"/> Lymphoscintigraphy	<input type="checkbox"/> UFE (Uterine Fibroid Embolization) <input type="checkbox"/> PAE (Prostate Artery Embolization) <input type="checkbox"/> Kyphoplasty <input type="checkbox"/> Sacroplasty <input type="checkbox"/> Port Check <input type="checkbox"/> Port Placement <input type="checkbox"/> Port Removal <input type="checkbox"/> IVC Filter Placement <input type="checkbox"/> IVC Filter Removal <input type="checkbox"/> IVC Filter Removal <input type="checkbox"/> Interventional Consultation	

\*These exams can be performed at all sites, but may benefit from being done with a pediatric radiologist onsite if under 18.

**SCHEDULING:**

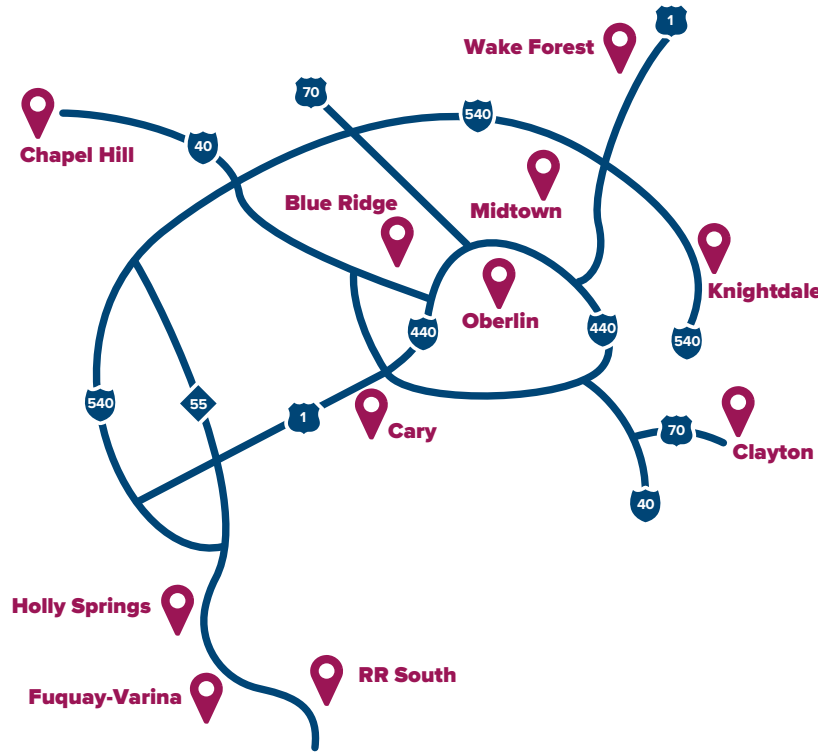
**PHONE 919.781.1437** (adult)  
**919.322.4538** (pediatric)

**FAX 919.787.4870**

**EMAIL schedulingteam@raleighrad.com**

**TAX ID & NPI** Blue Ridge, Cary, Fuquay-Varina, Knightdale:  
 NPI Number: 1952527343  
 Tax ID Number: 561465117

Chapel Hill, Clayton, Holly Springs, Midtown,  
 Oberlin, RR South, Wake Forest:  
 NPI Number: 1821694381  
 Tax ID Number: 85-4041225



● Some Offerings Available  
 Services may change. Please call for most current offerings.

	Blue Ridge	Cary	Chapel Hill	Clayton	Fuquay-Varina	Holly Springs	Knightdale	Midtown	Oberlin	RR South	Wake Forest
Bone Density (DEXA)	●	●	●	●	●	●	●	●	●		●
CT	●	●		●	●		●	●	●		●
CT Cardiac Calcium Scoring	●	●		●			●	●	●		●
3D Mammography™	●	●	●	●	●	●	●	●	●		●
Fast Breast MRI	●	●	●					●			
Fluoroscopy	●	●		●				●			●
Nuclear Medicine	●										
MRI/MRA	●	●	●	●		●	●	●			●
Pediatric Imaging	●	●	●	●	●	●	●	●	●	●	●
Therapeutic Joint Injection	●	●		●				●			●
Ultrasound	●	●	●	●	●	●	●	●	●	●	●
Vascular Ultrasound	●	●	●	●	●	●	●	●	●		●
Vascular and Interventional Services and Consultations								●			
Varicose and Spider Vein Treatments								●			
Walk-in Screening Mammograms			●	●	●	●	●	●	●		●
Walk-in X-Ray	●	●	●	●	●	●	●	●	●	●	●
Whole Body Screening MRI			●				●	●			

**Raleigh Radiology Blue Ridge**  
 3200 Blue Ridge Road, Suite 100  
 Raleigh, NC 27612

**Raleigh Radiology Cary**  
 150 Parkway Office Court, Suite 100  
 Cary, NC 27518

**Raleigh Radiology Chapel Hill**  
 120 Banks Drive, Suite 110  
 Chapel Hill, NC 27514

**Raleigh Radiology Clayton**  
 11618 Clayton Boulevard, Suite 102  
 Clayton, NC 27520

**Raleigh Radiology Fuquay-Varina**  
 601 Attain Street, Suite 100  
 Fuquay-Varina, NC 27526

**Raleigh Radiology Holly Springs**  
 1060 S. Main Street, Suite 110  
 Holly Springs, NC 27540

**Raleigh Radiology Knightdale**  
 1101 Great Falls Court, Suite 100  
 Knightdale, NC 27545

**Raleigh Radiology Midtown**  
 5111 Falls of Neuse Road, Suite 100  
 Raleigh, NC 27609

**Raleigh Radiology Oberlin**  
 505 Oberlin Road, Suite 110  
 Raleigh, NC 27605

**Raleigh Radiology South**  
 2400 North Main Street, Suite 150  
 Fuquay Varina, 27526

**Raleigh Radiology Wake Forest**  
 11640 Northpark Drive, Suite 110  
 Wake Forest, NC 27587

*Clinicians - if you need to consult with a pediatric radiologist and you are in the WakeMed system, we recommend you utilize "Rapid Connect" search "ped rad" and choose: "Raleigh Radiology-Pediatric On Call". A pediatric radiologist is on call 24/7.*