



# CT ORDER FORM

Pre-Authorization Number \_\_\_\_\_  
 Diagnoses/Indications: (Required for Reimbursement)  
 1. \_\_\_\_\_  
 2. \_\_\_\_\_  
 3. \_\_\_\_\_

Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Type of Order:  STAT  Routine  
 Call Result  Fax Result  
 Phone Number \_\_\_\_\_  
 Fax Number \_\_\_\_\_

| CPT   | HEAD  | CPT   | EXTREMITY  |
|-------|---|-------|--|
| 70450 | Head w/o IV contrast (ROUTINE)  | 73200 | Upper Extremity w/o IV contrast (ROUTINE)  |
| 70470 | Head w/wo IV contrast*  |       | <input type="checkbox"/> Right <input type="checkbox"/> Left Specify body part: _____          |
| 70486 | Facial Bone w/o IV contrast (ROUTINE) Attn: _____   | 73202 | Upper Extremity w/wo IV contrast*  |
| 70487 | Facial Bones with IV contrast* Attn: _____  |       | <input type="checkbox"/> Right <input type="checkbox"/> Left Specify body part: _____          |
| 70480 | Orbits w/o IV contrast (ROUTINE)  | 73200 | Bilateral Upper Extremity w/o IV contrast  |
| 70481 | Orbits with IV contrast*  |       | <input type="checkbox"/> Right <input type="checkbox"/> Left Specify body part: _____          |
| 70486 | Sinus w/o IV contrast (ROUTINE)   | 73202 | Bilateral Upper Extremity w/wo IV contrast*  |
| 70487 | Sinus with IV contrast*   |       | <input type="checkbox"/> Right <input type="checkbox"/> Left Specify body part: _____          |
| 70480 | Temporal Bones w/o IV contrast (ROUTINE)<br><input type="checkbox"/> IAC/Middle Ear <input type="checkbox"/> Mastoids | 73700 | Lower Extremity w/o IV contrast  |
|       | <b>SPINE</b>  |       | <input type="checkbox"/> Right <input type="checkbox"/> Left Specify body part: _____          |
| 72125 | Cervical Spine – Vertebra (Entire spine will be imaged)   | 73702 | Lower Extremity w/wo IV contrast*  |
| 72131 | Lumbar Spine – Vetebra (Entire spine will be imaged)  |       | <input type="checkbox"/> Right <input type="checkbox"/> Left Specify body part: _____          |
| 72128 | Thoracic Spine – Verebra (Entire spine will be imaged)  | 73700 | Bilateral Lower Extremity w/o IV contrast  |
| 72125 | Cervical Spine – Disc (post myelogram)  |       | <input type="checkbox"/> Right <input type="checkbox"/> Left Specify body part: _____          |
| 72131 | Lumbar Spine – Disc (post myelogram)  | 73702 | Bilateral Lower Extremity w/wo IV contrast   |
| 72128 | Thoracic Spine – Disc (post myelogram)  |       | <input type="checkbox"/> Right <input type="checkbox"/> Left Specify body part: _____          |
|       | <b>NECK</b>   | 72192 | Pelvis (bone)  |
| 70490 | Neck w/o IV contrast  |       |  |
| 70491 | Neck with IV contrast* (ROUTINE)  |       | <b>SPECIALS</b>  |
| 70491 | Sialography with IV contrast*<br>Attn: _____  | 77012 | <input type="checkbox"/> CT Guided Biopsy Specify location: _____                              |
|       | <b>CHEST</b>  |       | <input type="checkbox"/> Kidney Biopsy with Mayo consult                                       |
| 71260 | Chest with IV contrast only* (ROUTINE)  |       | <input type="checkbox"/> Checking for Lymphoma   |
| 71250 | Chest w/o IV contrast   |       | PT, PTT, INR needed prior to procedure (Supplies used will be charged to patient)              |
| 71275 | Chest for PE with IV contrast only*   | 75989 | <input type="checkbox"/> CT Drainage with Catheter placement                                   |
| 71250 | High Resolution Chest w/o IV contrast (ROUTINE) Prone and Supine  |       | Specify location: _____  |
| G0297 | Low Dose Lung Screening   |       | Labs needed on fluid collected: _____  |
| 75571 | Calcium Scoring Heart Scan w/o Contrast   |       | PT, PTT, INR needed prior to procedure (Supplies used will be charged to patient)              |
|       | <b>ABDOMEN/PELVIS</b>   |       | <input type="checkbox"/> PT, PTT, INR needed <input type="checkbox"/> Moderate sedation needed |
| 74176 | Renal Stone w/o IV contrast   |       | <b>CT ANGIOGRAPHY</b>  |
| 74178 | IVP w/wo IV contrast*   | 74175 | Abdominal Aorta with IV contrast only*(ROUTINE)  |
| 74160 | Abdomen with IV contrast* (ROUTINE) (diaphragm to iliac crest)  | 74150 | Abdominal Aorta w/o IV contrast  |
| 74150 | Abdomen w/o IV contrast (diaphragm to iliac crest)  | 71275 | Thoracic Aorta with IV contrast only* (ROUTINE)  |
| 74177 | Abdomen/Pelvis with IV contrast* (ROUTINE)  | 71250 | Thoracic Aorta w/o IV contrast   |
| 74176 | Abdomen/Pelvis w/o contrast   | 75635 | CTA Aorta with run off with IV contrast only   |
| 72193 | Pelvis with IV contrast* (ROUTINE)  | 74175 | CTA Renal Arteries w/wo IV contrast only*  |
| 72192 | Pelvis w/o contrast   | 74175 | CTA Mesenteric w/wo IV contrast only*  |
| 74170 | 3 Phase Liver/Pancreas w/wo IV contrast* (Abdomen Only)   | 71275 | CTA Chest with IV contrast only*   |
|       | <input type="checkbox"/> Check box if oral contrast (Gastroview) will be given instead of patient drinking water      | 70498 | CTA Carotid Arteries with IV contrast only*  |
|       | <b>INSTRUCTIONS:</b>  | 70496 | CTA Circle of Willis (Cerebral Arteries) with IV contrast only*                                |
|       |   | 73206 | CTA Upper Extremity with IV contrast only* location: _____                                     |
|       |   |       | <b>SCHEDULED DATE &amp; TIME:</b>  |

Exams with a \* include an order for Creatinine in patients that re age 60 or older or who have other risk factors for renal disease if one has not been obtained within the last 2 weeks. Contrast will not be given if GFR is less than 30. GFR levels between 30 and 40 will be evaluated by a radiologist regarding use of contrast.

DATE \_\_\_\_\_ TIME \_\_\_\_\_ SIGNATURE \_\_\_\_\_  
 Registration Fax: (217) 347-1377 Scheduling Phone: (217) 347-1540

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 Rev: 12/28/2017  
 2-18-2020 10:46:03 AM  
 503 North Maple Street • Effingham, Illinois 62401

