

**This form is part of the patient's medical record and must be completed for referral**



Date of Referral \_\_\_\_\_ Referring Provider Name \_\_\_\_\_  
 Patient Name (first, MI, last) \_\_\_\_\_  
 Patient Phone # (\_\_\_\_\_) \_\_\_\_\_ (home) (\_\_\_\_\_) \_\_\_\_\_ (work or cell)  
 D.O.B. \_\_\_\_\_ SS# \_\_\_\_\_

**Written Diagnosis/Reason/Symptom for Exam(s) REQUIRED**

Medicare and other insurers require coding of specific/definitive diagnosis(es), sign(s) or symptom(s) to reflect the "medical necessity" for each test.  
**Rule out, Possible or Probable Conditions cannot be coded.** For Medicare Policy information see the Part B Bulletin or [www.noridian.com/medweb](http://www.noridian.com/medweb)

**Notes:** Height \_\_\_\_\_ Weight \_\_\_\_\_ Breast cancer history Lt \_\_\_\_\_ Rt \_\_\_\_\_  
 Mastectomy history Lt \_\_\_\_\_ Rt \_\_\_\_\_  
 Allergies \_\_\_\_\_ Implants? Y \_\_\_\_\_ N \_\_\_\_\_  
 Physical Assistance Required

**PRIOR EXAMS:**  
 \_\_\_\_\_  
 Date of Service \_\_\_\_\_ Facility Location \_\_\_\_\_

**Breast Imaging & Bone Density**

**Screening Services**

**Mammography**

Screening Mammogram (no symptoms)

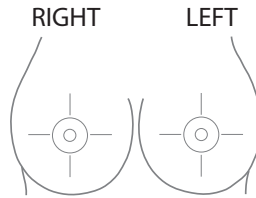
**Bone Densitometry (DEXA)**

Spine & Femur  
 Other (Specify) \_\_\_\_\_

**Diagnostic Services**

Diagnostic Mammogram **lt rt bilat**  
 (Ultrasound if needed)  
 Needle Biopsy if indicated  
 Needle Loc **lt rt bilat**  
 Stereotactic Breast Biopsy **lt rt bilat**  
 Galactogram **lt rt bilat**

*Indicate area of concern*



**Ultrasound**

Breast **lt rt bilat**  
 Breast Cyst Aspiration **lt rt bilat**  
 Guided Breast Biopsy **lt rt bilat**

**MRI exam**

**Pacemaker: Y / N** (if YES, MRI services unavailable)  
 Creatinine/GFR \_\_\_\_ / \_\_\_\_ (date drawn) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Breast MRI bilat with contrast  
 Limited Chest MRI if indicated (radiologist's discretion)  
 Breast MRI guided biopsy **lt rt bilat**

**Other Last Name:** \_\_\_\_\_  
**Appointments:**

**Exam** \_\_\_\_\_  
 Day/Date: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Check In Time \_\_\_\_\_ : \_\_\_\_\_  
 Appt. Time \_\_\_\_\_ : \_\_\_\_\_  
**Exam** \_\_\_\_\_  
 Day/Date: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Check In Time \_\_\_\_\_ : \_\_\_\_\_  
 Appt. Time \_\_\_\_\_ : \_\_\_\_\_

Call patient to schedule  
 Patient will call to schedule  
 Return patient to the office with films  
 Call STAT (\_\_\_\_)\_\_\_\_-\_\_\_\_\_  
 Fax STAT (\_\_\_\_)\_\_\_\_-\_\_\_\_\_  
 Fax Routine (\_\_\_\_)\_\_\_\_-\_\_\_\_\_

Send:  CD ROM  Films  
**Additional reports to:** \_\_\_\_\_

**PCP:** \_\_\_\_\_

**Name of insurance is required:**  
 \_\_\_\_\_

**Insurance authorization #**  
 (if needed): \_\_\_\_\_

**Original Signature REQUIRED by Referring Provider**  
 (Medicare B News Bulletin #256, 8/29/09) →

**For Office Use Only**

Diagnostic Imaging Phys Orders



**Radiology Order Form**

**THIS REFERRAL IS CONFIDENTIAL AND IS INTENDED SOLELY FOR THE USE OF THE MEDICAL PROVIDER NAMED ABOVE. IF YOU ARE NOT THE INTENDED RECIPIENT OR THE INTENDED RECIPIENT'S AGENT, AND HAVE RECEIVED THIS COMMUNICATION IN ERROR, NOTIFY SENDER IMMEDIATELY AND DESTROY THIS DOCUMENT.**

