SunCoast Diagnostic Imaging

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Accredited By American College of Radiology

PHYSICIANS ORDER

Monday - Saturday

Extended Evening Hours

We Certify Most Insurance Plans

Patient Name:_____DOB:_____/_____/_____ Wt: _____lbs. _____ht. _____

Patient Contact #: (_____) _____ - _____ _____ Male / Female

Diagnosis Code: _____Description: _____

Referring Physician: _____ Phone #:_____

Based on the patient's history, exam and diagnosis, I have requested the below listed exam(s). I hereby certify that the exam(s) are medically necessary.

Referring Physician Signature: _____NPI#:_____ Tax ID#: _____

☐ STAT Call Report to: (_____) _____ - _____ ☐ FAX Report to: (_____) _____ - _____

OPEN MRI

CONTRAST ☐ w/o ☐ w & w/o

- ☐ Brain
- ☐ Orbits
- ☐ IAC
- ☐ Pituitary
- ☐ Soft Tissue Neck
- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar
- ☐ Sacrum
- ☐ Brachial Plexus
- ☐ Abdomen
- ☐ Pelvis
- ☐ Shoulder R / L
- ☐ Scapula R / L
- ☐ Humerus R / L
- ☐ Elbow R / L
- ☐ Wrist R / L
- ☐ Hand R / L
- ☐ Hip R / L
- ☐ Femur R / L
- ☐ Lower Leg R / L
- ☐ Knee R / L
- ☐ Ankle R / L
- ☐ Foot R / L
- ☐ Other_____
- ☐ Other_____

MRA

- ☐ Brain / COW ☐ MRV
- ☐ Carotid
- ☐ Renal

XRAY

- ☐ Abdomen AP 1 view
- ☐ Ankle 3 + views R / L
- ☐ Cervical Spine AP/Lat only
- ☐ Cervical Spine 4 views w/obliques
- ☐ Cervical Spine w/obliques F/E
- ☐ Calcaneus 2+ views
- ☐ Chest PA only
- ☐ Chest PA/Lateral
- ☐ Elbow 3 + views R / L
- ☐ Eye Foreign Body
- ☐ Facial Bones 3 + views
- ☐ Femur 2 views R / L
- ☐ Fingers 2 + views R / L
- ☐ Foot 3 + views R / L
- ☐ Forearm 2 views R / L
- ☐ Hand 3 + views R / L
- ☐ Hip Bilateral w/pelvis
- ☐ Hip 2 + views R / L
- ☐ Humerus 2 + views R / L
- ☐ Knee 1 or 2 views R / L
- ☐ Knee 4 + views R / L
- ☐ Lumbar Spine AP/Lat
- ☐ Lumbar Spine AP/Lat/Obliques
- ☐ Lumbar Spine w/Bend view
- ☐ Pelvis AP only
- ☐ Ribs Bilateral 3 views
- ☐ Ribs Unilateral 2 views
- ☐ Ribs unilateral w/CXR 3 + views
- ☐ Shoulder 2 + views R / L

XRAY

- ☐ Sinuses 3 + views
- ☐ Thoracic /Lumbar Spine Scoliosis
- ☐ Thoracic Spine 3 views
- ☐ Tibia/Fibula 2 views R / L
- ☐ Toe(s) 2 + views R / L
- ☐ Wrist 3 views R / L
- ☐ Other_____

GENERAL ULTRASOUND

- ☐ Abdominal Complete
- ☐ Abdominal Limited
- ☐ Pelvic (Complete)
- ☐ Pelvic (Transvaginal)
- ☐ Renal
- ☐ Scrotal / Testicular
- ☐ Soft Tissue Neck
- ☐ Soft Tissue Extremity
- ☐ Thyroid
- ☐ Other_____

VASCULAR ULTRASOUND

- ☐ Carotid Complete
- ☐ Extremity Arterial Doppler Complete U / L
- ☐ Extremity Arterial Doppler Limited U / L
- ☐ Extremity Veins Complete
- ☐ Extremity Venous Doppler Complete U / L
- ☐ Extremity Venous Doppler Limited U / L
- ☐ Other_____

CARDIAC ULTRASOUND

- ☐ Cardiac Echo with Doppler

Please fax this completed form to: 850-747-8664