Imaging Order

Phone: 616-980-9050
Fax: 616-317-4920
office@theimagingcenter.org

Patient Information

Patient Name: _____ DOB: _____ Sex: ▢ Male ▢ Female

Street Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Email: _____

Ordering Physician Information

Physician Name: _____ NPI#: _____ Facility Name: _____

Facility Address: _____ Phone: _____ Fax: _____

Order(s) Requested	Diagnosis Code(s)	Contrast Needs
	Please use ICD-10 codes	▢ Per Radiologist Protocol ▢ Without ▢ With & Without ▢ With Only

Contrast Clearance

For patients needing contrast, we will need to have eGFR labs ordered and completed within 30 days prior* to imaging based on the following:

CT exam WITH orders

- ▢ 60 years of age or older
- ▢ Renal (kidney) disease

Exam Comments / Reason for Exam

Surgical History of Area Being Imaged

Payment Information

▢ Self-Pay ▢ Bill Insurance Primary Insurance: _____ Insurance ID#: _____

Group #: _____ Subscriber (if different than patient): _____ Subscriber DOB: _____

Physician Signature & Date: _____

Please email or fax the completed order along with copies of insurance cards.
Exams needing a prior authorization, please include relevant office notes with order.

The Imaging Center Tax ID: 83-3253583 NPI: 1023572831