



Imaging Order

Phone: 616-980-9050
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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

- Per Radiologist Protocol
- Without
- With & Without
- With Only

Please use ICD-10 codes

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.