



A Teaching Affiliate of Harvard Medical School



Radiology Department CT Exam

Radiology Fax: 617-573-3846

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****ALL PATIENTS 60 YEARS OF AGE OR OVER MUST HAVE BUN AND CREATININE LEVELS DRAWN WITHIN 1 YEAR PRIOR TO EXAM****

****ALL PATIENTS WITH A HISTORY OF DIABETES OR RENAL INSUFFICIENCY/DISEASE MUST HAVE A BUN AND CREATINE WITHIN 3 MONTHS OF EXAM****

Patient Information

Date:

Last Name:		First Name:		Middle Initial:	MRN#:
Date of Birth:		Home Phone #:		Work Phone #:	
Street Address:					
City:		State:		Zip:	
Insurance Carrier:			Referral / Authorization and/or Transaction #:		

CT Procedures with Contrast: *(Put X in box left of exam)*

CT Procedures Without Contrast: *(Put X in box left of exam)*

<input type="checkbox"/>	Brain with contrast 70460		<input type="checkbox"/>	Brain w/out contrast 70450	
<input type="checkbox"/>	Sinus with contrast 70487	VTI	<input type="checkbox"/>	Sinus w/out contrast 70486	VTI
<input type="checkbox"/>		3D 76376	<input type="checkbox"/>		3D 76376
<input type="checkbox"/>		Stealth	<input type="checkbox"/>		Stealth
<input type="checkbox"/>	Orbit with contrast 70487	3D 76376	<input type="checkbox"/>	Orbit w/out contrast 70480	3D 76376
<input type="checkbox"/>	Neck with contrast 70491	3D 76376	<input type="checkbox"/>	Neck w/out contrast 70490	3D 76376
<input type="checkbox"/>	Temporal with contrast 70481	3D 76376	<input type="checkbox"/>	Temporal w/out contrast 70480	3D 76376
<input type="checkbox"/>	Chest with contrast 71260		<input type="checkbox"/>	Chest w/out contrast 71250	
<input type="checkbox"/>	Mandible with contrast 70487	Dentascan	<input type="checkbox"/>	Mandible w/out contrast 70486	Dentascan
<input type="checkbox"/>		3D 76376	<input type="checkbox"/>		3D 76376
<input type="checkbox"/>	Abdomen with contrast 74160		<input type="checkbox"/>	Abdomen w/out contrast 74150	
<input type="checkbox"/>	Cervical spine with contrast 72126	3D 76376	<input type="checkbox"/>	Cervical spine w/out contrast 72125	3D 76376
<input type="checkbox"/>	Nasopharynx with contrast 70487	3D 76376	<input type="checkbox"/>	Nasopharynx w/out contrast 70486	3D 76376
<input type="checkbox"/>	Guidance for Needle Biopsy 77012	Fine Needle 10022	<input type="checkbox"/>	Other	
<input type="checkbox"/>	Biopsy muscle superficial 20200	Biopsy deep 20205	<input type="checkbox"/>		
<input type="checkbox"/>	Biopsy percutaneous needle 20206	Lymph Node 38505	<input type="checkbox"/>		
<input type="checkbox"/>	Biopsy thyroid 60100		<input type="checkbox"/>		

Additional Patient History (be specific):

Is patient diabetic? Y N If yes, what medication is patient on (i.e., glucophage)?

Date of Exam:	Time of Exam:	Initials:
Physician ordering exam <i>(print name)</i> :		Physician Signature <i>(required)</i> :
Phone extension:		