

REGIONAL RADIOLOGY SERVICES

ORDER FORM

PLEASE NOTE THAT ALL HIGHLIGHTED PORTIONS OF THE FORM ARE NEEDED FOR THE ORDER TO BE COMPLETE

For Radiology orders:

1. Mark the requested study(ies)
 2. Sign and date the form
 3. Fax request to: 855-416-3847- right fax
 4. Patient calls 303-338-3456 to schedule exams
- Hours of operation: Mon-Fri 7am- 6pm

Patient Name (Last, First)			
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Health Record Number:		DOB:		Gender:	
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Phone number:	
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Pertinent Medical Info. (e.g. weight, allergies, lab, LMP):	
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Ordering/Referring clinician (Please print):

Office Phone:		Fax Number:	
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Special Instructions:		CC:	
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Routine (w/in 2 weeks)	ASAP (1-2 Days)	Stat	CD: Y or N
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Sign or Symptom/Diagnosis:	What happened? When did it happen? Where should we focus? What are you concerned for?
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ICD 10 Code:	
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Magnetic Resonance (MR)	
Desired Study:	Contrast? Yes <input type="checkbox"/> No <input type="checkbox"/>

Cat Scan	
Desired Study:	Contrast? Yes <input type="checkbox"/> No <input type="checkbox"/>

Nuclear Medicine/ PET	
Desired Study:	

Ultrasound	
Desired Study:	

Mammography	
Desired Study:	Screening Diagnostic

BMD	
Desired Study:	

Fluoroscopy	
Desired Study:	

General Radiography	
Desired Study:	Right Left Bilateral

Ordering Clinician's Signature:		Date:
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