Dartmouth-Hitchcock

Manchester
Phone: (603) 695-2850
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Nashua
Phone: (603) 577-4070
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CT, MRI and MRA

Order / Pre-Authorization Form

Please complete this form for CT, MRI & MRA exams. If the facility changes OR the appointment falls after the Expiration Date, the authorization must be edited.

Patient Name: ______________________ Date: ____________

DOB: ______________________ MR #: ______________________

Ordering provider: ______________________ Billing provider: ______________________

Insurance: ______________________ ID #: ____________ Phone #: ____________

Diagnosis/ICD-9 Code: ______________________ Hosp/Facility: ______________________

Was this an injury? ❑ No ❑ Yes If yes, type of injury: ❑ WC ❑ MVA ❑ Other Date of injury: ____________

Clinical history (Why are you ordering this exam? What are you trying to R/O?): ______________________

____

How long has patient had these symptoms? ______________________

Medications patient is taking pertinent to this DX: ______________________

Does patient have a contrast allergy? ______________________

MRI PATIENTS ONLY (please ask ALL of the following questions):

Have Metal implants? ❑ No ❑ Yes Ever worked with Metal? ❑ No ❑ Yes Weight: ____________

HX of Claustrophobia? ❑ No ❑ Yes If yes, Rx needed: ______________________

Describe HX of Cancer or Surgery: ______________________

CT PATIENTS ONLY (please ask ALL of the following questions):

Diabetic? ❑ No ❑ Yes Take Glucophage? ❑ No ❑ Yes HX of Renal failure? ❑ No ❑ Yes

Asthma? ❑ No ❑ Yes ALLERGIES to Shellfish or Iodine? ❑ No ❑ Yes HX of Kidney disease? ❑ No ❑ Yes

Any prior imaging studies? ❑ No ❑ Yes Type of study: ______________________

Results: ❑ Negative ❑ Positive Explain positive finding: ______________________

Please check all that apply: 1) TEST REQUESTED: ❑ MRI ❑ MRA ❑ CT

2) TIMEFRAME NEEDED: ❑ Today ❑ Within 3 days ❑ More than 3 days

❑ Abdomen/Pelvis	❑ Brain	❑ Brachial Plexus	❑ Facial Bones	❑ Enterography	❑ Head
❑ Abdomen/Kidney Stones	❑ IAC's	❑ MRCP	❑ Mastoid	❑ Neck (for carotid)	❑ Orbits
❑ Breast Biopsy (Nashua)	❑ Breast	❑ Pituitary	❑ Sinus	❑ Neck (for soft tissue)	❑ TMJ's
❑ S-C Joints	❑ C-Spine	❑ Thoracic Spine	❑ Lumbar Spine	❑ Chest	

Please check all that apply: EXTREMITY: ❑ Left ❑ Right ❑ Bilateral

❑ Ankle	❑ Clavicle	❑ Elbow	❑ Femur	❑ Finger	❑ Foot
❑ Forearm	❑ Hand	❑ Hip	❑ Humerus	❑ Knee	❑ Lower Leg
❑ Scapula	❑ Shoulder	❑ Sternum	❑ Toe	❑ Wrist	

For Radiology Use Only:

Patient notified: ____________ Order faxed to Radiology: ____________ Test date: ____________

Booked: FU w/provider ____________ Appt. in DH4: ____________ Added to CIS Task List: ____________

PRE-AUTHORIZATION #: ______________________ EXPIRATION DATE: ______________________

TYPE OF STUDY APPROVED: ______________________