PARKER COUNTY IMAGING

parkercountyimaging.com

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For easy and convenient access to your patient reports, ask us about our Medical Professional Portal.

Appointment date and time	Check-in time	Patient DOB	Sex assigned at birth ☐ M ☐ F
Patient name (as shown on insurance card)		Primary phone #	Secondary phone #
Insurance name		Insurance ID #	Group #
☐ Auto ☐ Workers' comp ☐ Commercial/Private		Date of injury	Pre-authorization #

(REQUIRED) Written diagnosis/reason/symptom for exam(s). Must include **specific** clinical indications (such as location, context and severity) to support medical necessity for each test.

Is the exam/procedure related to an injury?
☐ No ☐ Yes If yes ☐ Initial ☐ Subsequent or ☐ Sequela

Clinical Decision Support (CDS) Required for Medicare Part B

Modifier (determination)	G-code (vendor)

☐ **R** ☐ **L** ☐ **BIL**

MRI

☐ IV contrast as clinically indicated by radiologist or
☐ No contrast
☐ Other _____

NEURO
☐ Brain and/or
☐ Orbits
☐ Volumetric brain imaging (NeuroQuant®)
☐ IACs
☐ Pituitary
☐ TMJ(s)
☐ Neck (soft tissue)

SPINE
☐ Cervical
☐ Thoracic
☐ Lumbar

BODY
☐ Chest
☐ Abdomen
☐ Liver
☐ Liver elastography
☐ Enterography (abd/pel)
☐ MRCP
☐ Pelvis

UPPER EXTREMITY
☐ Shoulder
☐ Elbow
☐ Wrist
☐ Hand

LOWER EXTREMITY
☐ Femur
☐ Knee
☐ Tibia/Fibula
☐ Ankle
☐ Foot

MRA
☐ Head
☐ Carotid
☐ Aorta w/runoff
☐ Renal

X-RAY

☐ Views _____
☐ Skeletal survey
☐ Spine
☐ Cervical
☐ Thoracic
☐ Lumbar
☐ Scoliosis series
☐ Chest
☐ Rib series
☐ Pelvis
☐ Hip(s)
☐ Other _____
☐ Abdomen/KUB
☐ Shoulder
☐ Humerus
☐ Elbow
☐ Forearm
☐ Wrist
☐ Hand
☐ Knee
☐ Ankle
☐ Foot

CT

☐ IV contrast as clinically indicated by radiologist OR
☐ No contrast
☐ 3D reconstructions as clinically indicated by radiologist OR
☐ No 3D reconstructions
☐ Heart calcium scoring
☐ Other _____

NEURO
☐ Head
☐ IAC/Temporal bones
☐ Facial bones
☐ Pituitary
☐ TMJ
☐ Neck (soft tissue)
☐ Sinus
☐ Complete O Limited

SPINE
☐ Cervical
☐ Thoracic
☐ Lumbar

BODY
☐ Chest
☐ Lung screening
☐ Abdomen
☐ Abdomen/Pelvis
☐ Enterography (abd/pel)
☐ Pelvis
☐ Hip(s)

UPPER EXTREMITY
☐ Shoulder
☐ Elbow
☐ Wrist
☐ Hand

LOWER EXTREMITY
☐ Knee
☐ Ankle
☐ Foot

CTA
☐ Brain
☐ Aorta
☐ Chest
☐ Abdomen
☐ Pelvis
☐ Lung (PE)
☐ Carotid
☐ Mesenteric
☐ Renal

3D MAMMOGRAPHY

Mammography coming soon. Please inquire with PCI directly if you have any questions when referring your patient.
☐ Screening or ☐ Diagnostic
☐ Screening mammogram, and if indicated, an additional diagnostic mammogram and/or breast ultrasound

ULTRASOUND

☐ Doppler if clinically indicated by radiologist OR ☐ No Doppler
☐ Transvaginal if clinically indicated by radiologist OR ☐ No transvaginal

☐ Abdomen complete (diaphragm to iliac crest)
☐ Aorta
☐ Breast
☐ Carotid artery
☐ Gallbladder
☐ Liver
☐ Liver Doppler
☐ Obstetric
☐ 1st trimester
☐ 2nd trimester
☐ 3rd trimester
☐ Pelvis (Iliac crest to pubic symphysis)
☐ Renal
☐ Bladder
☐ Other _____
☐ Scrotum
☐ Doppler
☐ Soft tissue
☐ Transvaginal
☐ Thyroid/ Parathyroid
☐ Arterial Doppler
☐ Lower extremity
☐ Venous Doppler
☐ Upper extremity
☐ Lower extremity

BONE DENSITY

☐ Screening or ☐ Diagnostic
History of pathological fracture? ☐ No ☐ Yes
Age-related osteoporosis w/o current pathological fracture? ☐ No ☐ Yes
Estrogen deficiency/clinical risk for osteoporosis? ☐ No ☐ Yes
Is patient taking FDA-approved osteoporosis drug or current long-term use of steroids?
☐ No ☐ Yes

Patient considerations (check all that apply)
☐ Claustrophobic ☐ Wheelchair ☐ Walker ☐ Cane ☐ Oxygen tank
☐ Sedation (all patients requiring sedation must have a driver)
Lab results: Creatinine _____ BUN _____ Blood draw date _____

REPORTING METHOD ☐ STAT call #_____ ☐ STAT fax # _____ ☐ STAT/ASAP
☐ CD to provider's office ☐ Patient to hand carry CD/report

Provider name (print)	Provider location	Phone #
Provider signature (required)	NPI # (required for new providers)	Date