

Adult Diagnostic Imaging Services Order/Referral

Today's Date: _____
 Patient Name: _____ Date of Birth: _____
 Home Phone: _____ Work Phone: _____ Mobile Phone: _____
 Diagnosis: _____
 Clinical Symptoms/History: _____

Clinical Decision Support Codes
G-code (Required for Medicare patients): _____

Vendor name (only for G1011): _____

HCPCS Modifier: _____

For scheduling information see the back or visit www.inova.org/radiology

Stat Reading/Wet Read

Diagnostic – No Appointment Necessary

Chest/Ribs	Skeletal	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Shoulder	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Knee	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Abdomen
<input type="checkbox"/> PA & LAT	<input type="checkbox"/> Fingers - Digit # _____	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Clavicle	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Femur	<input type="checkbox"/> KUB
<input type="checkbox"/> PA only	<input type="checkbox"/> Hand	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Toes - Digit # _____	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Hip	<input type="checkbox"/> Flat, Erect and PA Chest
<input type="checkbox"/> Decubitus <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Wrist	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Foot	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bone Age	Spine
<input type="checkbox"/> Ribs <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Forearm	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Ankle	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Scoliosis	<input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic
	<input type="checkbox"/> Elbow	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Tibia/Fibula	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Metabolic Bone Survey	<input type="checkbox"/> Lumbar <input type="checkbox"/> Sacrum/Coccyx
	<input type="checkbox"/> Humerus			Other (specify): _____

Examinations Requiring a Scheduled Appointment Time

<p>Ultrasound</p> <input type="checkbox"/> Abdominal (<input type="checkbox"/> w/Doppler, if checked) <input type="checkbox"/> Pelvis (<input type="checkbox"/> w/Doppler, if checked) <input type="checkbox"/> Transabdominal <input type="checkbox"/> Transabdominal w/Transvaginal <input type="checkbox"/> Chest <input type="checkbox"/> Renal/Retroperitoneal <input type="checkbox"/> Obstetrical (<input type="checkbox"/> w/TV, if checked) <input type="checkbox"/> BPP <input type="checkbox"/> w/Nonstress <input type="checkbox"/> Nonvascular Upper Extremity <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral <input type="checkbox"/> Nonvascular Lower Extremity <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral <input type="checkbox"/> Scrotal/Testicular (<input type="checkbox"/> w/Doppler, if checked) <input type="checkbox"/> Neck/Soft Tissue (Thyroid) <input type="checkbox"/> FNA (Thyroid) <input type="checkbox"/> Soft Tissue Abnormality – Location: _____ <input type="checkbox"/> Hysterosonogram (<input type="checkbox"/> w/pelvis, if checked) <input type="checkbox"/> Other: _____ <p>Ultrasound Guided Fine Needle Aspiration (FNA)</p> <input type="checkbox"/> USG FNA Specify Area: _____ <input type="checkbox"/> USG Biopsy Prostate <input type="checkbox"/> USG Lymph Node <input type="checkbox"/> FNA Thyroid <input type="checkbox"/> Other: _____ <p>Cardiac Ultrasound</p> <input type="checkbox"/> Stress Echocardiogram <input type="checkbox"/> Echocardiogram (ECHO) <input type="checkbox"/> Transesophageal Echocardiogram (TEE) <input type="checkbox"/> Other: _____ <p>Vascular Ultrasound</p> <input type="checkbox"/> Carotid Doppler <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral <input type="checkbox"/> Transcranial Doppler <input type="checkbox"/> Venous Duplex Upper Extremity <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral <input type="checkbox"/> Venous Duplex Lower Extremity <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral <input type="checkbox"/> Venous Insufficiency <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral <input type="checkbox"/> Aortic/IVC/Iliac Duplex <input type="checkbox"/> Arterial Segmental Pressures (PVR) <input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Arterial Duplex Upper Extremity <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral <input type="checkbox"/> Arterial Duplex Lower Extremity <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral <input type="checkbox"/> Duplex Abd/Pelvis/Retroperitoneal <input type="checkbox"/> Renal Arteries Only <input type="checkbox"/> Other: _____	<p>Breast Imaging</p> <input type="checkbox"/> Screening Mammo w/CAD (3D, comprehensive) (<input type="checkbox"/> U/S breast, if checked) <input type="checkbox"/> Comprehensive (3D, CAD, U/S, if requested) <input type="checkbox"/> Unilateral (w/breast U/S, if requested) <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Density Scan/DEXA <input type="checkbox"/> Stereotactic Biopsy/Location: _____ <input type="checkbox"/> USG Breast Cyst Aspiration/Location: _____ <input type="checkbox"/> USG Biopsy Breast/Location: _____ <input type="checkbox"/> Breast U/S (<input type="checkbox"/> w/comp mammo, if checked) <input type="checkbox"/> ABUS <input type="checkbox"/> Breast MRI: <input type="checkbox"/> Bilateral <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Other: _____ <p>Fluoroscopy</p> <input type="checkbox"/> Upper GI <input type="checkbox"/> Small Bowel/SBFT (if CT or MR Enterography is contraindicated) <input type="checkbox"/> Esophagram <input type="checkbox"/> VFSS/Modified Barium Swallow <input type="checkbox"/> Barium Enema <input type="checkbox"/> Hysterosalpingogram <input type="checkbox"/> VCUG <input type="checkbox"/> Other: _____ <p>Nuclear Medicine</p> <input type="checkbox"/> Bone Scan: <input type="checkbox"/> 3Phase <input type="checkbox"/> SPECT <input type="checkbox"/> Whole Body <input type="checkbox"/> Sentinel Node: Breast: <input type="checkbox"/> L <input type="checkbox"/> R Melanoma site: _____ <input type="checkbox"/> Myocardial Perfusion: <input type="checkbox"/> Stress <input type="checkbox"/> Pharmacological <input type="checkbox"/> Cardiac Amyloidosis (PYP) <input type="checkbox"/> MUGA Scan <input type="checkbox"/> EKG Treadmill Stress <input type="checkbox"/> Gallium Scan _____ <input type="checkbox"/> Tumor <input type="checkbox"/> Gastric Emptying <input type="checkbox"/> Solid <input type="checkbox"/> Liquid <input type="checkbox"/> Gastric Reflux (Milk Scan) <input type="checkbox"/> HIDA Scan <input type="checkbox"/> w/CCK <input type="checkbox"/> Parathyroid Scan <input type="checkbox"/> Thyroid with Uptake <input type="checkbox"/> I-131 therapy for hyperthyroid <input type="checkbox"/> Nuclear Cystogram <input type="checkbox"/> Renal Scan: <input type="checkbox"/> Captopril <input type="checkbox"/> w/Lasix <input type="checkbox"/> DMSA Scan <input type="checkbox"/> MIBG <input type="checkbox"/> Liver SPECT (Hemangioma Study) <input type="checkbox"/> Liver/Spleen <input type="checkbox"/> Cisternogram <input type="checkbox"/> WBC Labeled Scan (Indium, Ceretec) <input type="checkbox"/> VQ Scan <input type="checkbox"/> Quantitative <input type="checkbox"/> Octreoscan <input type="checkbox"/> Other: _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2" style="width: 80%;">CT Scan</th> <th colspan="3" style="text-align: center;">Contrast</th> </tr> <tr> <th style="width: 10%;">IV</th> <th style="width: 10%;">Oral</th> <th style="width: 10%;">w/w/o</th> </tr> </thead> <tbody> <tr> <td> <input type="checkbox"/> 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Referring Physician (signature): _____ Date: _____ Time: _____
 Referring Physician (print name): _____ Physician NPI: _____
 Referring Physician: Phone # _____ Fax # _____

To schedule your appointment call or visit:

571.423.5400
inova.org/radiology

Fax: 571.423.5477

Scheduling is open Monday – Friday, 8 a.m. – 6 p.m.

You can now schedule general mammography online in MyChart.

Requested arrival times:

- **Nuclear Medicine or MRI** – arrive 30 minutes prior to your appointment
- **All other imaging services** – arrive 15 minutes prior to your appointment

Please bring the following information with you:

- This form signed by your referring physician
- Insurance card
- Photo ID (i.e. license, passport)
- Any imaging and reports (i.e. x-rays, mammograms, MRIs, CT scans, and ultrasounds) from previous exams performed at non-Inova facilities
- Implant card, if applicable

For on-line scheduling, service locations, hours, and driving directions visit:
inova.org/radiology

Abbreviation Key:

Abd – Abdomen	HIDA – Hepatobiliary Iminodiacetic Acid	MRV – Magnetic Resonance Venography	TMJ – Temporomandibular Joint
ABUS – Automated Breast Ultrasound	IAC – Internal Auditory Canal	MRCP – Magnetic Resonance Cholangiopancreatography	TV – Transvaginal
BPP – Biophysical Profile	IV – Intravenous	MUGA – Multiple-Gated Acquisition	U/S – Ultrasound
CAD – Computer Aided Detection	IVC – Inferior Vena Cava	NM – Nuclear Medicine	USG – Ultrasound Guided
CCK – Cholecystokinin	I-131 – Iodine 131	PA – Posterior-Anterior	VCUG – Voiding Cystourethrogram
CT – Computed Tomography	KUB – Kidneys, Ureters, Bladder	PE – Pulmonary Embolism	VFSS – Videofluoroscopic Swallowing Study
CTA – CT Angiography	L – Left	PET – Positron Emission Tomography	VQ – Pulmonary Ventilation and Perfusion Scan
DEXA – Dual-energy X-ray Absorptiometry	LAT – Lateral	PYP – Pyrophosphate	WBC – White Blood Cells
DMSA – Dimercapto Succinic Acid	Mammo – Mammography	R – Right	w/ – With
EKG – Electrocardiogram	MIBG – Meta-iodobenzylguanidine	SBFT – Small Bowel Follow Through	w/o – Without
EXT – Extension	MR – Magnetic Resonance	SPECT – Single Photon Emission Computed Tomography	w/wo – With and without
Flex – Flexion	MRA – Magnetic Resonance Angiogram		
FNA – Fine Needle Aspiration	MRI – Magnetic Resonance Imaging		
GI – Gastrointestinal			