Imaging Request Form

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We provide prior authorization service

ALIGN RADIOLOGY

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Patient Name _____
DOB_____ Gender: M F
Phone #_____
Insurance _____
Reason for Exam/ICD_____

Provider Name _____
Phone#_____Fax#_____
Signature_____
Date_____ ❑ STAT

MRI/MRA (3T Wide Bore)

HEAD/NECK
❑ MRI Brain _____
❑ Pituitary ❑ Orbits ❑ IACs
❑ MRA Brain ❑ MRV Head
❑ MRA Neck ❑ MRI Neck

SPINE
❑ Cervical
❑ Thoracic
❑ Lumbar

EXTREMITIES – UPPER
❑ Shoulder ❑ L ❑ R
❑ Humerus ❑ L ❑ R
❑ Elbow ❑ L ❑ R
❑ Forearm ❑ L ❑ R
❑ Wrist ❑ L ❑ R
❑ Hand ❑ L ❑ R

EXTREMITIES – LOWER
❑ Hip ❑ L ❑ R
❑ Femur ❑ L ❑ R
❑ Knee ❑ L ❑ R
❑ Tibia/Fibula ❑ L ❑ R
❑ Ankle/Hindfoot ❑ L ❑ R
❑ Forefoot/midfoot ❑ L ❑ R

CHEST
❑ Routine
❑ MRA Chest
❑ Brachial plexus
❑ Other _____

ABDOMEN
❑ MRI Liver/Kidney
❑ MRI Pancreas/MRCP
❑ MRA Abdomen/Renal

PELVIS
❑ Bony ❑ SI joints/Sacrum
❑ Soft tissue ❑ Uterus
❑ Prostate ❑ Rectal
❑ MRV Pelvis

ABDOMEN/PELVIS
❑ Routine
❑ Enterography

CT/CTA (Low Dose)

HEAD/NECK
❑ CT Brain
❑ Sinus/Maxillofacial
❑ Temporal Bones/IAC
❑ Orbits
❑ Soft Tissue Neck

SPINE
❑ Cervical
❑ Thoracic
❑ Lumbar

CHEST
❑ Routine
❑ Low Dose Lung Screening
❑ Calcium Score

ABDOMEN ONLY
Specify: _____

ABDOMEN AND PELVIS
❑ Routine
❑ Stone Protocol
❑ Urogram
❑ Enterography

PELVIS ONLY
Specify: _____

OTHER
Specify: _____

CT ANGIOGRAPHY
❑ CTA Head
❑ CTA Neck
❑ CTA Chest - Aorta
❑ CTA Chest - PE Protocol
❑ CTA Abdomen & Pelvis
❑ CTA Lower Extremities
❑ Other _____

EXTREMITIES – UPPER
Specify: _____ ❑ L ❑ R

EXTREMITIES – LOWER
Specify: _____ ❑ L ❑ R

X-RAY

HEAD/NECK
❑ Skull
❑ Orbits
❑ Mandible
❑ Facial Bones
❑ Soft Tissue Neck

CHEST
❑ Chest PA and Lat
❑ Chest PA Only
❑ Ribs ❑ R ❑ L

ABDOMEN
❑ Flat and Upright
❑ KUB

PELVIS
❑ AP Supine
❑ AP Upright
❑ Sacrum & Coccyx
❑ SI Joints

SPINE
❑ Cervical
  ❑ AP/LAT/Open Mouth
  ❑ AP/LATObliques
  ❑ AP/LAT/Flex/Ext
  ❑ Complete with Flex/Ext
❑ Thoracic
❑ Lumbar
  ❑ AP/LAT
  ❑ AP/LAT with Obliques
  ❑ AP/LAT/Flex/Ext
  ❑ Complete with Flex/Ext

EXTREMITY
❑ Specify:_____
❑ L ❑ R
❑ Specify:_____
❑ L ❑ R
❑ Specify:_____
❑ L ❑ R

ULTRASOUND

ABDOMEN
❑ Routine/Complete
❑ RUQ/Limited
❑ Renal and Bladder

PELVIS
❑ Routine (with TV)
❑ OB 1st Trimester
❑ Scrotum
❑ Bladder

OTHER
❑ Neck
❑ Thyroid
❑ Other: _____

VASCULAR ULTRASOUND
❑ Carotid Doppler
❑ Abdominal Aorta
❑ Renal Artery Duplex
❑ Liver Doppler
❑ DVT Lower Extremity
  ❑ L ❑ R
❑ DVT Upper Extremity
  ❑ L ❑ R
❑ Lower Extremity Arterial Doppler ❑ L ❑ R
❑ Upper Extremity Arterial Doppler ❑ L ❑ R
❑ Other_____

❍ Contrast as determined by Radiologist
❍ Without Contrast ❍ With Contrast
❍ With and Without Contrast

Creatinine_____GFR_____ Date:_____