UAB MEDICINE
Department of Radiology

Ordering for Diagnostic Imaging (External)

www.uabmedicine.org/referradiology
UAB Medicine Imaging appointments: 205-801-8750

Patient Name: ______________________

Date of Birth: ______________________

Patient's contact number and e-mail: ______________________

Reason for Exam: ______________________

Signs and symptoms: ______________________

ICD 10 code: ______________________

CPT code: ______________________

Physician Name/ NPI# ______________________

Insurance information (Group/claim #): ______________________

Pre Cert/ Auth# (if needed) ______________________ **(same day or next day requests)**

Diagnostic Imaging:

Radiography(Xray) ☐ Fluoroscopy(GI) ☐ Mammography ☐ CT ☐ MRI ☐

Ultrasound ☐ Angiography ☐ Bone Density(DEXA) ☐

Other(specify) ______________________

Area(s) to be imaged: ______________________

Biopsy or aspiration: ______________________

Contrast:

Iodinated Contrast :	Without ☐	With ☐	Without and With ☐	Discretion of Radiologist ☐
Gadolinium Contrast:	Without ☐	With ☐	Without and With ☐	Discretion of Radiologist ☐

Creatinine(value, date, if available): ______________________

Allergies: ______________________

A member of our access team will contact you to obtain further information and arrange for an appointment. Special instructions, including preparation (if needed), will be provided at that time. If an authorization is required, please fax supporting clinical documentation to 205-731-5609

*** I understand that by hitting submit this will serve as an electronic signature that has the same legal effect and can be enforced in the same way as a written signature.**

Signed orders can also be faxed to 205-731-5609

Physician Signature (if not submitting electronically) ______________________

Contact Person: ______________ **Phone:** ______________ **Fax:** ______________

UAB F# 1626r4 (previously kfkra904) Developed: 4/20/02; Rev: 5/3/11, 3/21/14, Approved:9/29/15; Issued:9/30/15