

DIAGNOSTIC IMAGING REFERRAL REQUIREMENTS

BASICS

■ Patient

- ☐ Name
- ☐ DOB
- ☐ Contact Information
- ☐ Spoken Language

■ Referral

- ☐ MUST be submitted by an M.D. or clinic equivalent (PA-C, ARNP)
 - Name printed
 - Legible signature
- ☐ ICD-10 code
- ☐ CPT code
- ☐ Reason for Referral
- ☐ Chart Notes to support that Reason for Referral

IMAGING

■ X-Ray

- ☐ Body part and location (Ex: Left knee, Right great finger-thumb)
- ☐ Requested views

■ CT or CTA Scan

- ☐ Body part and location
- ☐ Has the clinic drawn for creatinine level? If not, provider must give permission to draw if deemed necessary.
- ☐ With or Without Contrast or Both?
 - If with Contrast, the clinic must know if the patient is allergic.
 - Have they taken contrast before?

■ Ultrasound

- ☐ Body part and location
- ☐ Requested views

■ MRI or MRA

- ☐ Body part and location
- ☐ Are they Diabetic?
- ☐ Any metal or pacemakers?
- ☐ Has the clinic drawn for creatinine level? If not, provider must give permission to draw if deemed necessary.
- ☐ With or Without Contrast or Both
 - If with Contrast, the clinic must know if the patient is allergic.
 - Have they taken contrast before?

■ Other Imaging

- ☐ Please refer to the above guidelines.

Special Needs

- ☐ Does the patient require any physical accommodations?
- ☐ Is the patient claustrophobic?
- ☐ Does the patient require an interpreter?
- ☐ Does the patient have any metal or medical implants that will interfere with the imaging process?