Patient Name:

DOB:

MR #:

UW Health
(University of Wisconsin Hospitals and Clinics Authority)
RADIOLOGY EXAM / PROCEDURE ORDER

Index to Imaging Request
Date: _____

Radiology Modality Type Requested (check one below)
☐ BMD ☐ Breast Imaging ☐ CT ☐ Diagnostic Radiology ☐ GI/GU ☐ Interventional Radiology ☐ MRI ☐ Nuc Med
☐ PET ☐ Ultrasound Specific Study needed: _____

Information needed for Radiology Order
Diagnosis and/or ICD-10: _____
What specific questions would you like answered by this exam? _____
_____
Decision Support URL: https://qcdsm.nationaldecisionsuppport.com Vendor Name of qCDSM Consulted: _____
Decision Support Session ID: _____ Decision Support Score: _____
Exam adheres to appropriate use criteria: ☐ Yes ☐ No ☐ N/A
Who should we contact to coordinate scheduling an appointment? (check one): ☐ Referring Clinic ☐ Patient

Please indicate below if you have an appointment location preference.
☐ UWMF **608-287-2050** (includes 1 So. Park, HERI, WIMR, Odana Atrium, Yahara, Union Corners, Deforest/Windsor)
☐ UWHC **608-263-9729** (includes The American Center, University Hospital, Research Park, Digestive Health Center, East/West Clinics, American Family Children's Hospital)

Patient Information *(Or please include a face sheet)*
Gender: ☐ Male ☐ Female
Address: _____ City: _____ State: _____ Zip: _____
Parent's Name (if a minor): _____
Guardian or Representative (if any): _____
Interpreter: ☐ Yes ☐ No Language: _____
Preferred Phone#: _____ Phone Type: ☐ Home ☐ Work ☐ Cell

Patient Insurance Information
Name of Insurance (if no insurance, indicate none): _____
Member ID: _____

Referring Provider Information
Referring Provider: _____
Clinic Contact Name and telephone #:_____
Clinic
Address:_____
(Street) (City) (State) (Zip)
Fax Number: _____
Comments:_____
_____
_____

☐ Permission to include/exclude contrast media usage per Radiologist/protocol.

The signature below and transmission of this Order for Care certifies that he/she: (1) is a licensed health care professional with the authority and expertise to order the care specified herein; (2) has evaluated the patient identified herein and asserts that the care specified herein is medically necessary and ordered; and (3) UW Health may rely upon this Order for Care for all purposes, including without limitation billing third party payers.

Signature: _____ Date: _____ Time: _____ Pager#: _____