

ORTHOPEDIC SPECIALTY ORDERS

Patient Name: _____ DOB: _____

Appt. Date/Time: _____ Patient Phone: (H) _____ (C) _____

Requesting Physician: _____ (please print) Phone _____

Health Insurance: _____ Policy #: _____ Group #: _____

Authorization #: _____ Call Patient to Schedule Precert then schedule (if allowed)

Is the patient pregnant? Yes No Patient Weight: _____

Physician Signature: _____ Office Contact: _____

Hold & Call Read & Call Contact Name & Phone: _____

MRI	<p>CONTRAST: <input type="checkbox"/> Without Contrast <input type="checkbox"/> With/Without Contrast <input type="checkbox"/> Contrast at Radiologist's Discretion <input type="checkbox"/> Arthrogram</p> <p>Open Magnet? <input type="checkbox"/> Yes <input type="checkbox"/> No Sedation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> iSTAT OR BUN: _____ Creatinine: _____ Date: _____</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> SHOULDER</td> <td><input type="checkbox"/> FOREARM</td> <td><input type="checkbox"/> SI JOINT</td> <td><input type="checkbox"/> HIP/BONY PELVIS</td> </tr> <tr> <td><input type="checkbox"/> ELBOW</td> <td><input type="checkbox"/> WRIST</td> <td><input type="checkbox"/> SC JOINTS</td> <td><input type="checkbox"/> THIGH</td> </tr> <tr> <td><input type="checkbox"/> HUMERUS/ARM</td> <td><input type="checkbox"/> HAND</td> <td></td> <td><input type="checkbox"/> CALF</td> </tr> <tr> <td></td> <td><input type="checkbox"/> FINGER</td> <td></td> <td><input type="checkbox"/> KNEE</td> </tr> <tr> <td></td> <td></td> <td></td> <td><input type="checkbox"/> ANKLE</td> </tr> </table> <p><input type="checkbox"/> OTHER: _____</p> <p>RX and Indications: _____ <i>(please print)</i></p>	<input type="checkbox"/> SHOULDER	<input type="checkbox"/> FOREARM	<input type="checkbox"/> SI JOINT	<input type="checkbox"/> HIP/BONY PELVIS	<input type="checkbox"/> ELBOW	<input type="checkbox"/> WRIST	<input type="checkbox"/> SC JOINTS	<input type="checkbox"/> THIGH	<input type="checkbox"/> HUMERUS/ARM	<input type="checkbox"/> HAND		<input type="checkbox"/> CALF		<input type="checkbox"/> FINGER		<input type="checkbox"/> KNEE				<input type="checkbox"/> ANKLE
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SN	<p>Extremity Imaging: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral</p> <p>1. RX and Indications: _____ <i>(please print)</i></p> <p>_____</p> <p>2. RX and Indications: _____ <i>(please print)</i></p> <p>_____</p>																				

SCHEDULING: Phone: 720-493-3700 Fax: 720-874-4400
Web: www.invisionsallyjobe.com