



IMAGING ORDER FORM

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Order Date:			
Patient's Name:			DOB:
Cell Phone:		Home Phone:	Last 4 Digits of SSN:
☐ Attorney Name:	☐ Attorney Phone:		☐ Worker's Comp. DOI: (Please attach)
Insurance	ID#	Auth#	
Referring Physician: (Print)	Physician Signature:	Patient Signature:	
Phone:	Fax:		
REPORT REQUEST: ☐ Web PACS ☐ EMAIL ☐ FAX IMAGE ACCESS: ☐ Report Only ☐ Web PACS ☐ CD			I hereby give Las Vegas Imaging authorization to verify insurance, obtain pre-certification, and schedule the patient. Diagnosis:
CPT MRI SPINE/NEURO		CPT MRI BODY Cont.	
70551	BRAIN W/O	77058	BREAST (IMPLANTS)
70553	BRAIN W + W/O	74181	ABDOMEN W/O
70553	PITUITARY W + W/O	74183	ABDOMEN W + W/O
70543	ORBITS W + W/O	74181	MRCP
72141	CERVICAL W/O	CPT MRA	
72156	CERVICAL W + W/O	70544	MRA BRAIN (COW)
72146	THORACIC W/O		
72157	THORACIC W + W/O	70547	CAROTIDS & VERTEBRALS
72148	LUMBAR W/O	CPT CT	
72158	LUMBAR W + W/O	74176	ABDOMEN & PELVIS W/O
CPT MRI UPPER EXTREMITY		74177	ABDOMEN & PELVIS W
73221	SHOULDER W/O R L	74178	ABDOMEN & PELVIS W + W/O
73221	ELBOW W/O R L	74150	ABDOMEN W/O
73221	WRIST W/O R L	74170	ABDOMEN W + W/O
73218	HAND W/O R L	72192	PELVIS W/O
CPT MRI LOWER EXTREMITY		72193	PELVIS W
72195	PELVIS W/O	71250	CHEST W/O
72197	PELVIS W + W/O	71260	CHEST W
73721	HIP W/O R L	70450	HEAD W/O
73723	HIP W + W/O R L	70470	HEAD W + W/O
73718	FEMUR W/O R L	70486	SINUS W/O
73721	KNEE W/O R L	70490	SOFT TISSUE NECK W/O
73718	TIB/FIB W/O R L	72125	CERVICAL W/O
73721	ANKLE W/O R L	72131	LUMBAR W/O
73718	FOOT W/O R L	72128	THORACIC W/O
73720	FOOT W + W/O R L	70480	CT ORBITS
CPT MRI BODY		71275	CHEST PE PROTOCOL
70336	TMJ		UPPER EXT. _____
70543	NECK (SOFT TISSUE) W + W/O		LOWER EXT. _____
71550	CHEST W/O		CTA _____
71552	CHEST W + W/O		
CPT DEXA 77080 AXIAL SKELETON (SPINE & HIPS) BODY MASS COMPOSITION CPT ULTRASOUND 76700 ABDOMEN 76705 GALLBLADDER/LIVER 76770 RENAL/KIDNEY 76870 SCROTUM/TESTICULAR 76801 OB-COMplete <14 WEEKS 76805 OB-COMplete >14 WEEKS 76856 PELVIC NON-OB 76536 THYROID 76830 TRANSVAGINAL SOFT TISSUE _____ 76645 BREAST (UNILATERAL R L /BILATERAL) CPT VASCULAR ULTRASOUND ___ LEFT ___ RIGHT ___ BILATERAL ___ UPPER ___ LOWER 93926 ARTERIAL 93880 CAROTID DOPPLER 93971 VENOUS X-RAYS (Specify procedure & number of views) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ OTHER PROCEDURES/SPECIAL INSTRUCTIONS 1. _____ 2. _____ 3. _____ 4. _____			