Advanced Radiology

MAMMO U/S, CT

Central Scheduling: 203.337.XRAY (9729)
Fax: 203.337.9730 **Online: Orders.AdRad.com**
AdRad.com Tax ID #06-1614148

◯ Fairfield	◯ Orange	◯ Shelton	◯ Stamford	◯ Stratford	◯ Trumbull	◯ Wilton
1055 Post Road Fairfield, CT 06824	297 Boston Post Road Orange, CT 06477 **(X-Ray, U/S, Arthro ONLY)**	4 Corporate Dr. Suite 182 Shelton, CT 06484	1259 East Main Street Stamford, CT 06902	2876 Main St. Stratford, CT 06614	15 Corporate Dr. Trumbull, CT 06611	30 Danbury Road Wilton, CT 06897

Patient Name _____

DOB _____ Preferred Phone # _____

Patient Email _____

Appt. Date/Time _____

Insurance _____

ID# _____

Prior Auth Req.? ☐No ☐Yes Auth.# _____

AFTER HRS/STAT CALL BACK # _____

Referring Practitioner (please print)

Name _____

Phone # _____

Signature _____

Date _____ CC: _____

CDS Code _____ **HCPCS Mod.** _____

G-Code _____

◯ **With Contrast**
◯ **Without Contrast**
◯ **With *AND* Without Contrast**

Signs and Symptoms _____

ICD-10 Codes _____

Rule out / History of / Question of _____

Mammography

☐ **Bilateral** ☐ **Left** ☐ **Right**

- ☐ **Screening** 3D Mammo: Excl. Shelton & Orange
- ☐ **Diagnostic** 3D Mammogram Trumbull, Stamford, Wilton ONLY
- ☐ Stereotactic Breast Biopsy: Trumbull ONLY
  ☐ Bilateral ☐ Left ☐ Right
- ☐ **Approval of add'l diagnostic mammogram, ultrasound, image- guided biopsy or cyst aspiration, as indicated by the Radiologist, for the left, right or bilateral breasts.**

Breast Ultrasound

☐ **Bilateral** ☐ **Left** ☐ **Right**

- ☐ **Screening:** Trumbull, Stamford, Wilton ONLY
- ☐ **Diagnostic:** Trumbull, Stamford, Wilton ONLY
- ☐ US-Guided Cyst Aspiration: Stamford, Trumbull, Wilton ONLY
- ☐ US-Guided Breast Biopsy Stamford, Trumbull, Wilton ONLY

Breast MRI

Fairfield, Stamford, Trumbull, Wilton ONLY

☐ **Bilateral** ☐ **Left** ☐ **Right**

- ☐ MRI-Guided Breast Biopsy
- ☐ **Fast Breast MRI (SELF-PAY ONLY)**

Bone Densitometry

- ☐ DEXA: Trumbull, Stamford, Stratford, Wilton ONLY

Diagnostic X-Ray

- ☐ Skull
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine
- ☐ Scoliosis Series: EXCL. Shelton, Orange
- ☐ Sinuses
- ☐ Chest
- ☐ Ribs
- ☐ Abdomen
- ☐ Pelvis
- ☐ Extremity: ☐ Left ☐ Right (Please specify)

_____

- ☐ Metastatic Series
- ☐ Other: (Please specify)

_____

Ultrasound

- ☐ Abdomen
- ☐ Abdomen w/Elastography
- ☐ Aorta
- ☐ Appendix
- ☐ Inguinal Hernia
- ☐ Umbilical Hernia
- ☐ Retroperitoneal (Kidneys)
- ☐ Extremity (Non-vascular)
  ☐ Bilateral ☐ Left ☐ Right
- ☐ Scrotum
- ☐ Thyroid
- ☐ Soft Tissue Neck
- ☐ Thyroid FNA

Pelvic:

- ☐ Transabdomnial
- ☐ Transvaginal

Doppler:

- ☐ Carotid
- ☐ **Venous Extremity - DVT**
  ☐ Bilateral ☐ Left ☐ Right
  ☐ Arm ☐ Leg
- ☐ **Arterial Extremity**
  ☐ Bilateral ☐ Left ☐ Right
  ☐ Arm ☐ Leg
- ☐ Abdominal
- ☐ Mesenteric Ischemia
- ☐ Renal Artery Stenosis

Pediatric:

- ☐ Spine
- ☐ Hips
- ☐ Brain
- ☐ Pylorus
- ☐ Appendix

Fluoroscopy Trumbull ONLY

- ☐ Upper GI Series
- ☐ Small Bowel Series
- ☐ Esophagram
- ☐ Other: (Please specify)

_____

CT Scan Excluding Wilton and Orange

Neuro:

- ☐ Brain
- ☐ Neck
- ☐ Orbits
- ☐ Temporal Bones

Sinuses:

- ☐ Full (Coronal and Axial)
- ☐ Limited

Spine: ☐ **3D**

- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar

Chest:

- ☐ Chest
- ☐ Lung Screen
- ☐ CTPA Pulmonary Embolism Protocol
- ☐ High Res (Interstitial Lung Disease)
- ☐ Calcium Score: Stamford, Shelton, Trumbull ONLY
- ☐ Coronary CTA: Shelton ONLY

Abdomen / Pelvis:

- ☐ Abdomen and Pelvis
- ☐ Volumen (CT Enterography)
- ☐ Hematura Protocol ☐ **3D**
- ☐ Liver Mass Protocol
- ☐ Abdomen Only
- ☐ Pelvis Only
- ☐ Urinary Stone Localization
- ☐ Extremities
  ☐ Left ☐ Right ☐ **3D**
- ☐ AAA Protocol
- ☐ CTA _____
- ☐ Runoff
- ☐ Other: (Please specify)

_____

Nuclear Medicine

Trumbull ONLY

- ☐ Bone Scan - Whole Body
- ☐ Bone Scan - Three Phase
- ☐ Gastric Emptying
- ☐ HIDA Scan
- ☐ HIDA Scan with CCK
- ☐ Liver/Spleen Scan
- ☐ Hemangioma Scan
- ☐ Lung Scan V/Q
- ☐ Parathyroid Scan
- ☐ I-123 w/Uptake Thyroid Scan
- ☐ Technetium Thyroid Scan
- ☐ I-123 Whole Body Scan
- ☐ I-131 Whole Body Scan
- ☐ I-131 Thyroid Treatment
- ☐ Renal Scan - Split Function
- ☐ Renal Scan with Lasix
- ☐ Renal Scan with Vasotec (hypertension)
- ☐ Renal DMSA Scan
- ☐ MUGA Scan
- ☐ Gallium Scan
- ☐ Infection Imaging - WBC Scan
- ☐ Infection Imaging - WBC/Marrow Scan
- ☐ Inium III - WBC Scan
- ☐ Octreotide Scan
- ☐ MIBG Scan
- ☐ Single Bone/Joint (Specify body part)

_____

Advanced Radiology

MRI

Central Scheduling: 203.337.XRAY (9729)
Fax: 203.337.9730 **Online: Orders.AdRad.com**
AdRad.com Tax ID #06-1216029

High Field Wide-Bore MRI Centers

☐ **Fairfield**
1055 Post Rd.
Fairfield, CT 06824

☐ **Orange**
297 Boston Post Rd.
Orange, CT 06477

☐ **Trumbull**
15 Corporate Dr.
Trumbull, CT 06611

☐ **Stamford**
1259 East Main St.
Stamford, CT 06902

☐ **Wilton**
30 Danbury Rd.
Wilton, CT 06897

High Field MRI Centers

☐ **Shelton**
4 Corporate Dr.
Suite 182
Shelton, CT 06484

☐ **Stratford**
2876 Main St.
Stratford, CT 06614

Patient Name _____

DOB _____ Preferred Phone # _____

Patient Email _____

Appt. Date/Time _____

Insurance _____

ID# _____

Prior Auth Req.? ☐No ☐Yes Auth.# _____

AFTER HRS/STAT CALL BACK # _____

Referring Practitioner (please print)

Name _____

Phone # _____

Referring Signature _____

Date _____ CC: _____

☐ Without Contrast

☐ With ***AND*** Without Contrast

Lab Values for Contrast Exams:

☐ eGFR _____

☐ Lab: _____

_____

Date _____

Height _____ Weight _____ Sex: M F ☐ **Claustrophobic**

Implanted Medical Devices (please specify) _____

Manufacturer and Model No. _____

Pertinent History / Special Instructions _____

Signs and Symptoms _____

ICD-10 Codes _____

Of clinical importance:
Rule out / History of / Question of _____

Brain

☐ Brain
☐ Spectroscopy

NeuroQuant:
☐ Brain w/ and w/o
☐ Brain w/o

Head and Neck

☐ Orbits
☐ Soft Tissue Neck/Parotid
☐ Brachial Plexus: ☐ Right ☐ Left
☐ Other: (Please specify)

_____

Spine

☐ Cervical Spine
☐ Thoracic Spine
☐ Lumbar Spine
☐ Total Spine Series
☐ Lumbosacral Plexus

Body

☐ Abdomen: (specify)_____
☐ Abdomen w/MRCP
☐ Chest: (specify)_____
☐ Pelvis: (specify)_____
☐ MRCP
☐ Prostate (3T Preferred)
☐ Enterography: w/ and w/o contrast

Breast MRI

☐ Bilateral

MRA Studies

☐ Head: Circle of Willis
(High Field Preferred)
☐ MRV Head
☐ Neck: Carotid
(w/ and w/o Preferred)
☐ Chest
☐ Renal
☐ Run-Off
☐ Other: (Please specify)

_____

Please Check If Applicable:

☐ Acute Stroke
☐ Cranial Nerve
☐ Seizure
☐ Pituitary
☐ IAC / Post Fossa
☐ NPH / Dementia
☐ MS
☐ Myelopathy
☐ Acute Trauma
☐ Metastasis
☐ Compression Fracture

Musculoskeletal System

☐ **ARTHROGRAM REQUESTED**

☐ Shoulder: ☐ Right ☐ Left
☐ Elbow: ☐ Right ☐ Left
☐ Wrist: ☐ Right ☐ Left
☐ Hand: ☐ Right ☐ Left
☐ Fingers: ☐ Right ☐ Left
☐ Hip: ☐ Right ☐ Left
☐ Knee: ☐ Right ☐ Left
☐ Ankle: (to include hind/mid foot)
☐ Right ☐ Left
☐ Ankle: (to include Achilles)
☐ Right ☐ Left
☐ Foot: (to include metatarsals/toes)
☐ Right ☐ Left
☐ Upper Extremity Other Than Joint:
☐ Right ☐ Left

_____
(Please specify body part)

☐ Lower Extremity Other Than Joint:
☐ Right ☐ Left

_____
(Please specify body part)

☐ Other: (Please specify)

_____

Advanced Radiology

Central Scheduling: 203.337.XRAY (9729)
Fax: 203.459.0116 Online: Orders.AdRad.com
Tax ID #06-1614148

PLEASE NOTE: All PET/CT studies are performed at 15 Corporate Drive, Trumbull, CT 06611.
Our PET/CT scanner uses non-diagnostic, low-dose CT for attenuation correction and anatomic localization.

All orders must be signed by the ordering practioner. Copies of both sides of the patient's insurance cards must be faxed with this order before an appointment can be scheduled. Advanced Radiology will contact the patient and physician after insurance confirmation to schedule the appointment and provide additional instructions.

Patient Name _____

☐ Male ☐ Female DOB _____

Preferred Phone # _____

Appt. Date/Time _____

AFTER HOURS/STAT CALL BACK # _____

Referring Practitioner (please print)

Name _____

Phone # _____

Referring Signature _____

Date _____ CC: _____

Primary Insurance/ID# _____

Pre-Cert. Req.? ☐No ☐Yes Pre-Cert.# _____

Secondary Insurance/ID# _____

Pre-Cert. Req.? ☐No ☐Yes Pre-Cert.# _____

Patients's Clinical History:

_____

_____

_____

_____

_____

_____

Patient's Signs and Symptoms:

_____

_____

_____

_____

_____

_____

Where? Side of interest?
☐ Right ☐ Left ☐ Bilateral ☐ RUQ ☐ LUQ ☐ RLQ ☐ LLQ ☐ N/A

Of clinical importance: Rule out / History of / Question of:

_____

_____

_____

_____

_____

ICD-10 Codes:

_____

_____

_____

_____

PET/CT Reason:

Cancer Type: _____

_____

_____

☐ Initial:
PET/Non-diagnostic Computed Tomography (CT) to inform the initial treatment strategy of tumors that are biopsy-proven or strongly suspected of being cancerous based on other diagnostic testing.

☐ Subsequent:
PET/Non-diagnostic Computed Tomography (CT) to inform the subsequent treatment strategy of cancerous tumors when the beneficiary's treating physician determines that the PET study is needed to inform subsequent anti-tumor strategy.

☐ 78608 - Brain, Dementia (FDG / AMYVid)

☐ 78608 - Brain, Seizure

☐ 78815 - Skull to Mid-Thigh

☐ 78459 - Myocardial Viability

☐ 78815 - Pulmonary Nodule Evaluation

☐ 78814 - Limited

☐ 78816 - Whole Body (Melanoma)

☐ 78811 - 78816 (Carrier dependent)
G0235 (Medicare)
Infection / Inflammation (Vascullitis)

☐ Other: (Please specify)

_____

_____

_____

Is the patient diabetic?

☐ Yes
☐ Type 1 ☐ Type 2 ☐ Unknown
☐ No

Is the patient on insulin?

☐ Yes
What Type? _____
☐ No

Is the patient on metformin?

☐ Yes
☐ No

What is the patient's morning glucose level?

_____

Medication History

☐ Recent Chemotherapy
Date _____

☐ Radiation
Date _____

☐ Prior Surgery
Date _____
Facility _____

☐ Prior Biopsy
Date _____
Facility _____

☐ Colony Stimulating Factor Therapy
Date _____

☐ Steroid Use
Date _____

☐ Newpogen
Date _____

☐ Neulasta
Date _____

Advanced Radiology

Call to Schedule an Appointment: 203.337.XRAY (9729)
Fax: 203.337.9730 Online: Orders.AdRad.com
Tax ID #06-1614148

CT Low Dose Lung Screening

CT Lung Screens are performed at the following Advanced Radiology clinical locations:

☐ Fairfield	☐ Shelton	☐ Stamford	☐ Stratford	☐ Trumbull
1055 Post Road Fairfield, CT 06824	4 Corporate Dr. Suite 182 Shelton, CT 06484	1259 East Main Street Stamford, CT 06902	2876 Main St. Stratford, CT 06614	15 Corporate Dr. Trumbull, CT 06611

Patient (please print)

Name_____

☐Male ☐Female DOB _____

Preferred Phone # _____

Referring Practitioner (please print)

Name_____

Phone # _____

NPI # _____

Referring Signature

Date_____ CC: _____

☐ **Initial Lung Screening**
For Initial Lung Screenings: Beneficiary must receive a written order for LDCT lung cancer screening during a lung cancer screening counseling and shared decision making visit, furnished by a physician or qualified non-physician practitioner (physician assistant, nurse practitioner, or clinical nurse specialist).

☐ **Subsequent/Annual Lung Screening**
For Subsequent/Annual Lung Screenings: Beneficiary must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner (physician assistant, nurse practitioner, or clinical nurse specialist). **For Lung-RAD 1 or 2 patients ONLY.**

The Centers for Medicare & Medicaid Services (CMS) has determined that the evidence is sufficient to add a lung cancer screening counseling and shared decision-making visit, and for appropriate beneficiaries, annual screening for lung cancer with low dose computed tomography (LDCT), as an additional preventive service benefit under the Medicare program **only if all of the following criteria are met:**

☐ **Diagnosis Code ICD-10 Z87.891**
Personal history of nicotine dependence

☐ **Patient is between 55 and 77 years of age**

☐ **Patient is currently a smoker**

☐ **Patient has quit smoking within the last _____ years (must be 15 years or less)**

☐ **Patient has a minimum 30 pack/year smoking history:**
Packs/Day (20 cigarettes/pack) _____ X Years _____ =
Pack Years _____

☐ **The patient is asymptomatic**
(no signs or symptoms of lung cancer)

A lung cancer screening counseling and shared decision-making visit must include the following, which must also be documented in the patient's medical history:

- Determination of beneficiary eligibility including age, absence of signs or symptoms of lung cancer, a specific calculation of cigarette smoking pack-years; and if a former smoker, the number of years since quitting
- Shared decision making, including the use of one or more decision aids, to include benefits and harms of screening, follow-up diagnostic testing, over-diagnosis, false positive rate, and total radiation exposure
- Counseling on the importance of adherence to annual lung cancer LDCT screening, impact of comorbidities, and ability or willingness to undergo diagnosis and treatment
- Counseling on the importance of maintaining cigarette smoking abstinence if former smoker; or the importance of smoking cessation if current smoker and, if appropriate, furnishing of information about tobacco cessation interventions
- If appropriate, the furnishing of a written order for lung cancer screening with LDCT; Written orders for both initial and subsequent LDCT lung cancer screenings must contain the following, which must also be documented in the patient's medical record:
  - Beneficiary's date of birth
  - Actual pack/year smoking history number
  - Current smoking status and/or number of years since quitting
  - Confirmation that patientis asymptomatic
  - NPI of the referring practioner

Advanced Radiology

Call to Schedule an Appointment: 203.386.3164
Fax: 203.380.3252 Online: Orders.AdRad.com
Tax ID #06-1614148

PLEASE NOTE: All Interventional Radiology procedures are performed at 2876 Main Street, Stratford, CT, 06614.

All orders must be signed by the ordering practioner. Copies of both sides of the patient's insurance cards must be faxed with this order before an appointment can be scheduled. Advanced Radiology will contact the patient and physician after insurance confirmation to schedule the appointment and provide additional instructions.

Patient Name _____

☐ Male ☐ Female DOB _____

Preferred Phone # _____

Appt. Date/Time _____

AFTER HOURS/STAT CALL BACK # _____

Referring Practitioner (please print)

Name _____

Phone # _____

Referring Signature

_____

Date _____ CC: _____

Primary Insurance/ID# _____

Pre-Cert. Req.? ☐No ☐Yes Pre-Cert.# _____

Secondary Insurance/ID# _____

Pre-Cert. Req.? ☐No ☐Yes Pre-Cert.# _____

Patients's Clinical History:

_____

_____

_____

_____

_____

_____

Patient's Signs and Symptoms:

_____

_____

_____

_____

_____

_____

Where? Side of interest?

☐ Right ☐ Left ☐ Bilateral ☐ RUQ ☐ LUQ ☐ RLQ ☐ LLQ ☐ N/A

Of clinical importance: Rule out / History of / Question of:

_____

_____

_____

_____

_____

ICD-10 Codes:

_____

_____

_____

_____

Exams / Special Instructions:

_____

_____

_____

_____

_____

_____

☐ Ambulatory Phlebectomy
☐ Biliary Tube Change
☐ Cyst Aspiration: Specify Body Part

_____

☐ Epidural
☐ Endovenous Radiofrequency Ablation
☐ Interventional Oncology Consultation
☐ EVLT
☐ Liver Biopsy
☐ Lumbar Puncture
☐ Lymph Node Needle Biopsy
☐ Myelogram Lumbar
☐ Nephrosomy Tube Change
☐ PICC Placement
☐ PICC Removal
☐ Paracentesis
  ☐ DIagnostic
  ☐ Therapeutic
☐ Porta Cath Insertion
☐ Sclerotherapy: Spider Veins
☐ Steroid Injection: Specify Body Part

_____

☐ Thoracentesis
  ☐ DIagnostic
  ☐ Therapeutic
☐ Thyroid Biopsy
☐ Thyroid FNA
☐ Tunneled CV Cath
☐ VCUG: Pediatric ONLY (under 24 months)

Procedural Details / Additional Comments:

_____

_____

_____

_____

_____

_____

Advanced Radiology®
INTERVENTIONAL RADIOLOGY

Call to Schedule an Appointment: 203.386.3164
Tax ID #06-1614148 **Fax: 203.380.3252**

Patient Name _____

DOB _____ Preferred Phone # _____

Patient Email _____

Appt. Date/Time _____

Insurance _____

ID# _____

Referring Practitioner (please print)

Name _____

Phone # _____

Signature _____

Date _____ CC: _____

Pertinent history / Special Instructions _____

_____

Additional Cross-Sectional Imaging Recommendations

☐ **Check here if you would like the patient to receive additional cross-sectional imaging deemed appropriate or necessary by the Interventional Physician, which may include X-ray, Ultrasound, CT scan, or MRI in relation to the selected procedure below.**

☐ **Renal Ablation includes the following conditional orders:**
One-month, six-month, and 12-month follow-up: CT Abdomen with IV contrast **or** MRI Abdomen with and without IV contrast

☐ **Liver Ablation includes the following conditional orders:**
One-month, three-month, six-month, and 12-month follow-up: CT Abdomen with IV contrast **or** MRI Abdomen with and without IV contrast

☐ **Lung Ablation includes the following conditional orders:**
One-month and three-month follow-up CT Chest with IV contrast ,and six-month follow-up PET/CT, with a possible twelve-month follow-up PET/CT

☐ **Y90 / Chemoembolization includes the following conditional orders:**
Three-month, six-month, and 12-month follow-up: CT Abdomen with IV contrast **or** MRI Abdomen with and without IV contrast

☐ **Uterine Fibroid Embolization includes the following conditional orders:**
Pre-procedure MRI Pelvis with and without IV contrast, six-month follow-up MRI Pelvis with and without IV contrast

☐ **Kyphoplasty includes the following conditional orders:**
Initial MRI Spine, two-week follow-up spinal x-ray

Biopsy results patient notification:

◯ The radiologist or the PA may notify the patient with results of the radiology biopsy procedure

◯ I prefer to contact the patient with biopsy results

The patient will be involved in all decisions about their care, treatment, and services provided. There may be some deviations from planned schedules of follow-up imaging and care, depending on patient circumstances and clinical situation. These will be communicated to the patient and referring physician as needed.

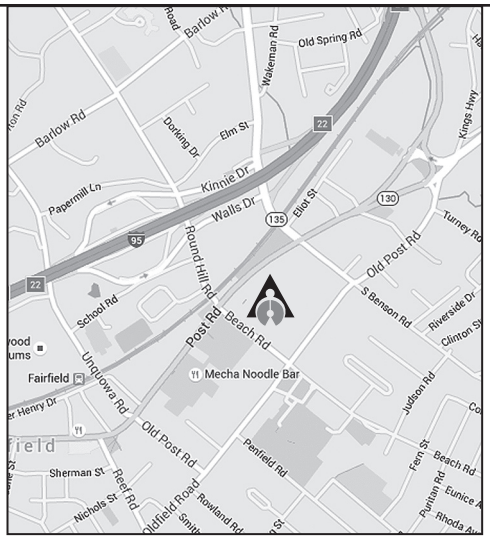
This order expires 13 months after the order date.

PREPARING FOR YOUR VISIT

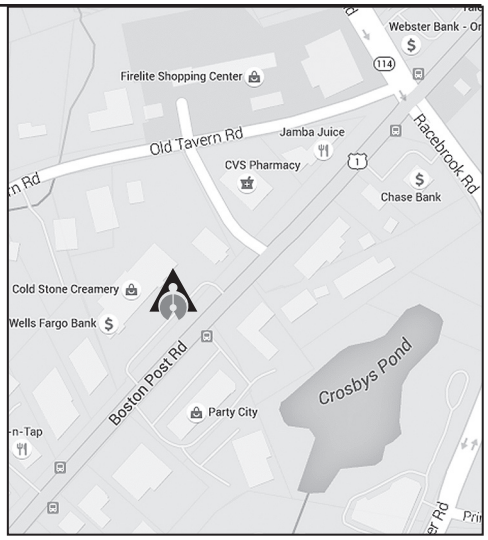
When you schedule your appointment, you will receive information about any preparation that is specific to your exam. Please bring this prescription and arrive 15 minutes before your scheduled appointment. Late arrival may mean cancellation of your appointment. If you must cancel, please do so a minimum of 24 hours prior to your appointment time.

Please be sure to bring the following:

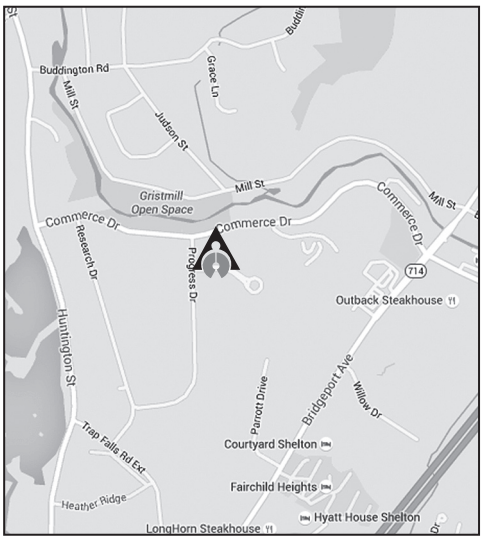
- ☐ **Photo ID**
- ☐ **Insurance information:** Please bring your insurance card or proof of insurance coverage. In order to bill your insurance carrier(s) for services rendered, we will need the name of the carrier (company), their complete mailing address, your policy's group number, and your personal identification number. If you are covered by Medicare or Medicaid, please bring the appropriate card.
- ☐ **Medications:** Please bring a list of all medications and dosages, including all over the counter medicines you currently use.
- ☐ **Prior Imaging:** If you have had any relevant prior imaging performed anywhere other than Advanced Radiology, please bring the images to your appointment. This includes mammograms.
- ☐ **Payment:** You will be responsible for services not covered by insurance, including co-pays. Advanced Radiology accepts cash, check, or major credit card (MasterCard, Visa, or American Express).



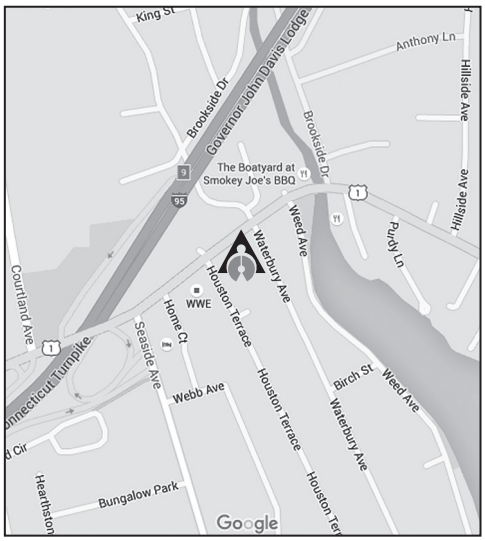
Fairfield
1055 Post Road



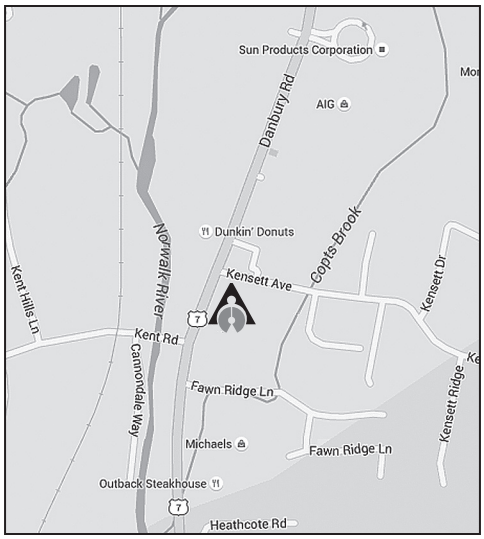
Orange
297 Boston Post Road



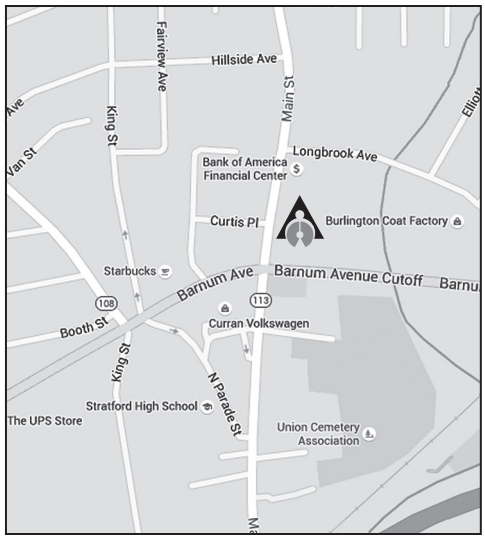
Shelton
4 Corporate Drive



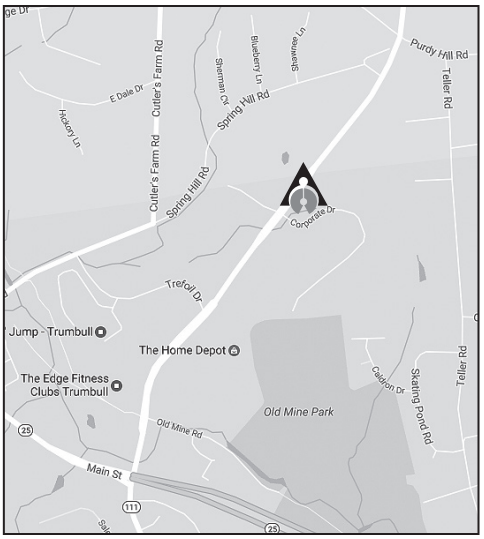
Stamford
1259 East Main Street



Wilton
30 Danbury Road



Stratford
2876 Main Street



Trumbull
15 Corporate Drive