APPOINTMENT CENTRAL
CT SCAN PHYSICIAN ORDER FORM
www.stjosephhospital.com

* 3 P0 *

PATIENT INFORMATION

Last Name	First Name	MI	DOB	SEX M F
Street Address			Home Phone No.	
City	State	Zip	Subscriber Name	
Insurance Name	Policy Number		Relationship to Patient ☐ Self ☐ Spouse ☐ Dependent	

Date of Test: _____
Time of Test: _____ am/pm
Patient to arrive at: _____ am/pm

Special Instructions:
☐ Hold & Call ☐ Send & Call
☐ Send Films with Patient ☐ Lab work also

*** Indicates test subject to medical necessity requirements**

CT SCAN

☐ CT Head w/o contrast *
☐ CT Head w/o and with contrast
☐ CT Sinus w/o contrast
☐ CT Sinus limited w/o contrast
☐ CT IAC/Mastoids w/o contrast
☐ CT IAC/Mastoids with contrast
☐ CT Facial bones w/o contrast
☐ CT Face soft tissue with contrast (does not include mandible)
☐ CT Mandible bone w/o contrast
☐ CT Mandible soft tissue with contrast
☐ CT Orbit bones w/o contrast
☐ CT Orbits soft tissue with contrast
☐ CT Soft tissue neck with contrast
☐ CT Soft tissue neck w/o and with contrast (to identify stones)
☐ CT Cervical spine w/o contrast
☐ CT Thoracic spine w/o contrast
☐ CT Lumbar spine w/o contrast

☐ CT Lung CA Screening
☐ CT Chest w/o contrast
☐ CT Chest with contrast
☐ CT Chest high resolution w/o contrast
☐ CT Heart calcium Score
☐ CT Liver w/o and with contrast (abdomen w/o and with)
☐ CT AAA w/o contrast (abdomen w/o)
☐ CT Kidney w/o and with contrast (abdomen w/o and with)
☐ CT Adrenal glands w/o and with contrast (abdomen w/o and with)
☐ CT Pancreatic mass w/o and with contrast (abdomen w/o and with)
☐ CT Helical calculi survey w/o contrast (abdomen/pelvis w/o)
☐ CT Extremity (please specify) _____
☐ CT Pelvic Bone (pelvis w/o)

☐ CT Enterography (Arrive 1 hour prior to exam) (abdomen/pelvis with)
☐ CT Appendix-IV and rectal contrast (abdomen/pelvis with)
☐ CT Urogram w/o and with contrast includes kidneys, ureters and bladder (abdomen/pelvis w/o and with)
☐ CT Diverticular Study-IV and rectal contrast (abdomen/pelvis with)
☐ CT Abdomen with contrast * (only includes upper quadrant)
☐ CT Pelvis with contrast * (requires oral contrast) (only includes lower quadrant)
☐ OTHER _____

Patients requiring oral contrast may pick it up prior to the date of the exam Monday through Friday 8 am to 7 pm.

Clear liquids only 4 hours prior to exam for all studies requiring contrast.

CT ANGIOGRAMS WITH IV CONTRAST

☐ CTA Head
☐ CTA Neck
☐ CTA Run-off (starts at dome of liver goes to toes)
☐ CTA Abdomen (indicate area of interest)
☐ CTA Pelvis (indicate area of interest)
☐ Renal Arteries
☐ Mesenteric Arteries
☐ Abdominal Aorta
☐ CTA Chest (indicate area of interest)
☐ Pulmonary Arteries
☐ Thoracic Aorta
☐ CTA Coronary/Arteries

ICD 9 CODE or Reason for test REQUIRED HERE for each test ordered. See reverse side for reference list **only.**

Physician Signature: _____ **NPI #** _____ **Physician Phone #:** _____

Copies to _____

ST. JOSEPH HOSPITAL
NASHUA, NH 03061

Scheduling
Phone: 603-598-3323
Fax: 603-578-5058

Place Label Here