St. Tammany PARISH HOSPITAL

Schedule an appointment: 985-871-5665
Outpatient Pavilion Radiology: 985-898-3700
Hospital Radiology: 985-898-4427
Fax OPP orders to: 985-898-3749
Fax hospital orders to: 985-871-5762

OUTPATIENT **RADIOLOGY** ORDER

1202 S. Tyler St., Covington LA 70433
Outpatient Pavilion, 16300 Hwy. 1085, Covington

Patient name: _____ Date of birth: _____
Physician/Practitioner: _____ Appt Date: _____
Insurance: _____ Policy# _____ Appt Time: _____
Clinical description: _____ Location of Appt: ☐OPP ☐Hospital
Routine ☐ Stat ☐ Authorization # _____

X-ray	ICD-9
☐ Abd-KUB ___ R obl ___ L obl	
☐ Abd 2 view flat & erect	
☐ Bone Age	
☐ Chest - 2 views (Decub. __L ___R)	
☐ Extremity: (specify) _____ ___L ___R	
☐ Facial bones	
☐ Joint survey	
☐ Ribs ___ L ___ R	
☐ Cervical spine	
☐ Lumbar spine	
☐ Thoracic spine	
☐ Scoliosis Series ☐ Metastatic Survey	
☐ Sinus ☐ Skull	
☐ Other _____	
Fluoro	
☐ BE* ☐ HSG	
☐ Upper GI ☐ Esophogram	
☐ Small bowel* ☐ IVP*	
☐ Modified BA Swallow w/Speech Therapy	
☐ Arthrogram(specify)_____	
Hospital only ☐VCUG	
☐ Myelogram (specify)_____	
Ultrasound	
☐ Abdominal (NPO) ☐ Gallbladder (NPO)	
☐ Liver (NPO) ☐ Aorta (NPO)	
☐ Kidneys (Drink 20oz Water)	
☐ Kidneys w/ Doppler (NPO)	
☐ Pelvic (Drink 32oz Water 1hr before appt)	
☐ Transvaginal	
☐ OB (full bladder)_____Biophysical Profile	
☐ Appendix ☐ Thyroid	
☐ Testicular ☐ Carotid	
☐ Infant Hips ☐ Sacral/Spine	
☐ Echoencephalograhy	
☐ Noninvasive venous duplex	
___ Arm ___L ___R	
___ Leg ___L ___R	
☐ Noninvasive arterial duplex	
___ Arm ___L ___R	
___ Leg ___L ___R	
☐ Nonvascular extremity	
☐ Other:_____	

Cat Scan	ICD-9
☐ Abd & Pelvis*	
☐ Upper Abd*	
☐ Adrenal*	
☐ Chest	
☐ Chest PE Study	
☐ High-res. chest	
☐ Coronary artery/Calcium scoring	
☐ Head ☐ Sinus	
☐ Facial ☐ IAC	
☐ Kidney* ☐ Pancreas*	
☐ Urinary tract stone study	
☐ S.T. neck	
☐ Cervical spine w/3D recons	
☐ Lumbar spine T12-L3 w/3D	
☐ Lumbar spine L3-S 1 w/3D	
☐ Thoracic spine w/3D	
☐ CT angiography w/3D	
Specify:_____	
☐ CT extremity w/3D __L __R	
Specify:_____	
☐ Other: _____	
Nuclear Medicine *(hospital only)*	
☐ Bone scan	
☐ Thyroid	
☐Myocardial rest	
☐ Myocardial stress	
☐ Myocardial rest & stress	
☐ Renal	
☐ Lung	
☐ Other:_____	

Please check For IV Contrast
☐ With Contrast
☐ With out Contrast
☐ With and With out Contrast

** Requires prep. Prep kits may be picked up at OPP for flouro and at the hospital for all other procedures noted with an asterisk (*)*

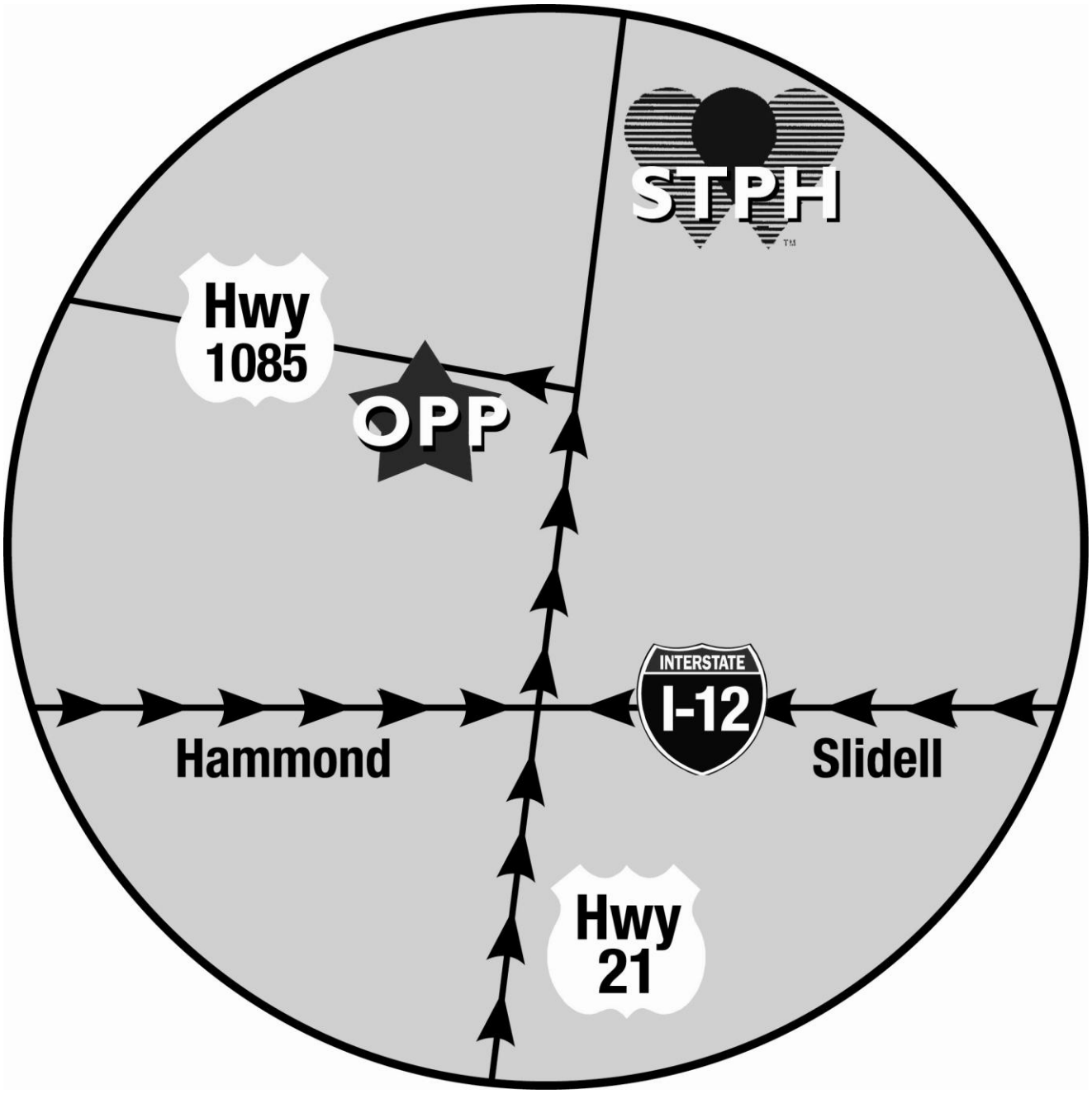
Required with CT and IVP contrast
BUN 84520
Creatnine 82565

MRI	ICD-9
Head	
☐ Brain ☐ IAC	
☐ Orbit ☐ Parotid	
☐ Pituitary ☐ Sinus	
☐ Nasopharynx	
Body	
☐ Abdomen ☐ Neck	
☐ Kidney ☐ Chest	
☐ Pancreas ☐ Prostate	
☐ Liver ☐ Pelvis	
☐ Adrenal ☐ Heart	
Spine	
☐Cervical ☐Lumbar	
☐ Thoracic ☐ SI joint	
☐ Sacrum-Coccyx	
☐ Brachial plexus ____L ____R	
Joint	
☐ Knee ____L ____R	
☐ Shoulder ____L ____R	
☐ Hip ____L ____R	
☐ Ankle ____L ____R	
☐ Elbow ____L ____R	
☐ Wrist ____L ____R	
☐ Arthogram	
Extremity	
☐ Foot/Toe ____L ____R	
☐ Forearm ____L ____R	
☐ Hand ____L ____R	
☐ Humerus ____L ____R	
☐ Lower leg ____L ____R	
☐ Thigh ____L ____R	
☐ Other:_____	
BREAST	
☐Breast Bilateral w/wo	
MRA (includes contrast)	
☐ Chest ☐ Head	
☐ Renal ☐ Neck	
☐ Abdomen (aorta)	
☐ Upper ext ___L___R	
☐ Lower ext ___L___R	

Map on reverse

Physician/Practitioner Signature: _____ Date: _____

I understand only tests or panels approved by Medicare medically necessary for diagnosis or treatment of a Medicare/Medicaid patient will be reimbursed. I certify that the above ordered test(s) is/are medically necessary and understand that if unnecessarily ordered, I may be subject to civil penalties under the False Claims Act.


STPH
Hwy
1085
OPP
INTERSTATE
I-12
Hammond
Slidell
Hwy
21