



APPOINTMENT DETAILS: _____

CALL PATIENT TO SCHEDULE OBTAIN AUTHORIZATION STAT CALL REPORT: _____

PATIENT INFORMATION	PROVIDER INFORMATION
Patient Name: _____	Provider Name: _____
Date of Birth: _____	Signature: _____ Date: _____
Phone: _____	Provider Phone: _____
Insurance: _____	Provider Fax: _____
Policy/Group #: _____ / _____	Authorization #: _____

DIAGNOSIS / HISTORY / SPECIAL INSTRUCTIONS	MEDICARE ONLY - REQUIRED AS OF 1/01/2022
_____	AUC/CDS G Code: _____ Modifier: _____
_____	CPT Code Submitted: _____

MRI	CT	Ultrasound	X-Ray / Dexa
Radiologist to recommend contrast, unless otherwise specified here: _____		<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral <input type="checkbox"/> Weight Bearing <input type="checkbox"/> Flexion/Extension # of views: _____ <i>If none specified, standard protocol will be performed.</i>
<input type="checkbox"/> Brain <input type="checkbox"/> Attn: IAC <input type="checkbox"/> Attn: Pituitary	<input type="checkbox"/> Head	<input type="checkbox"/> Aorta	<input type="checkbox"/> Chest (one view)
<input type="checkbox"/> Orbits	<input type="checkbox"/> Orbits	<input type="checkbox"/> Breast	<input type="checkbox"/> Chest (PA & Lat)
<input type="checkbox"/> TMJ	<input type="checkbox"/> Facial Bones	<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Ribs (Includes one view chest)
<input type="checkbox"/> Soft Tissue Neck	<input type="checkbox"/> IACs/Temporal Bones	<input type="checkbox"/> Abdomen Complete	<input type="checkbox"/> Cervical Spine
<input type="checkbox"/> Brachial Plexus	<input type="checkbox"/> Sinus	<input type="checkbox"/> Abdomen Limited (specify) _____	<input type="checkbox"/> Thoracic Spine
<input type="checkbox"/> Breast <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilat	<input type="checkbox"/> Soft Tissue Neck	<input type="checkbox"/> Pelvis w/ TV if indicated	<input type="checkbox"/> Lumbar Spine
<input type="checkbox"/> MRA Brain	<input type="checkbox"/> CTA Head	<input type="checkbox"/> Scrotum	<input type="checkbox"/> Abdominal Series
<input type="checkbox"/> MRV Brain	<input type="checkbox"/> CTA Neck	<input type="checkbox"/> Renal	<input type="checkbox"/> Abdomen (KUB)
<input type="checkbox"/> MRA Carotid	<input type="checkbox"/> CTA Chest (PE Protocol)	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Scoliosis Series
<input type="checkbox"/> MRA Renal	<input type="checkbox"/> CTA Aorta/Run-off	<input type="checkbox"/> ABI	<input type="checkbox"/> Pelvis
<input type="checkbox"/> MRA Aorta/Run-off	<input type="checkbox"/> Chest	<input type="checkbox"/> Soft Tissue (specify) _____	<input type="checkbox"/> TMJ
<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> Lung Screening	<input type="checkbox"/> 1st Trimester / Early OB	<input type="checkbox"/> Skull
<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/> Abdomen/Pelvis	<input type="checkbox"/> Arterial Doppler <input type="checkbox"/> Lower <input type="checkbox"/> Upper	<input type="checkbox"/> Facial Bones
<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/> Stone Protocol (Abd/Pelvis)	<input type="checkbox"/> Venous Doppler <input type="checkbox"/> Lower <input type="checkbox"/> Upper	<input type="checkbox"/> Nasal Bones
<input type="checkbox"/> MRCP	<input type="checkbox"/> Abdomen <input type="checkbox"/> Adrenals <input type="checkbox"/> Liver	<input type="checkbox"/> Ext. Non-Vascular <input type="checkbox"/> Lower <input type="checkbox"/> Upper	EXTREMITIES <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral <input type="checkbox"/> Weight Bearing
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Pancreas <input type="checkbox"/> Kidney	<input type="checkbox"/> Renal Artery Doppler	<input type="checkbox"/> Clavicle <input type="checkbox"/> Shoulder
<input type="checkbox"/> Pelvis	<input type="checkbox"/> Pelvis	<input type="checkbox"/> AAA Screening	<input type="checkbox"/> Humerus <input type="checkbox"/> Elbow
<input type="checkbox"/> Sacrum/Coccyx	<input type="checkbox"/> Cervical Spine		<input type="checkbox"/> Forearm <input type="checkbox"/> Wrist
<input type="checkbox"/> Prostate	<input type="checkbox"/> Thoracic Spine		<input type="checkbox"/> Hand <input type="checkbox"/> Finger
	<input type="checkbox"/> Lumbar Spine		<input type="checkbox"/> Hip <input type="checkbox"/> Femur
EXTREMITIES <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral	EXTREMITIES <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral		<input type="checkbox"/> Knee <input type="checkbox"/> Tib/Fib
<input type="checkbox"/> Shoulder <input type="checkbox"/> Humerus	<input type="checkbox"/> Shoulder <input type="checkbox"/> Humerus		<input type="checkbox"/> Ankle <input type="checkbox"/> Foot
<input type="checkbox"/> Elbow <input type="checkbox"/> Forearm	<input type="checkbox"/> Elbow <input type="checkbox"/> Forearm		<input type="checkbox"/> Toe
<input type="checkbox"/> Wrist <input type="checkbox"/> Hand	<input type="checkbox"/> Wrist <input type="checkbox"/> Hand		<input type="checkbox"/> DEXA _____
<input type="checkbox"/> Hip <input type="checkbox"/> Femur	<input type="checkbox"/> Hip <input type="checkbox"/> Femur		
<input type="checkbox"/> Knee <input type="checkbox"/> Tib/Fib	<input type="checkbox"/> Knee <input type="checkbox"/> Tib/Fib		
<input type="checkbox"/> Ankle <input type="checkbox"/> Forefoot	<input type="checkbox"/> Ankle <input type="checkbox"/> Foot		
<input type="checkbox"/> Midfoot <input type="checkbox"/> Heel/Calcaneous			

Mammography / Women's Imaging	Other
<input type="checkbox"/> Screening Mammo <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilat w/ diagnostic and/or breast US if indicated	
<input type="checkbox"/> Diagnostic Mammo <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilat w/ breast US if indicated	
<input type="checkbox"/> Breast US <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilat	<input type="checkbox"/> DEXA _____

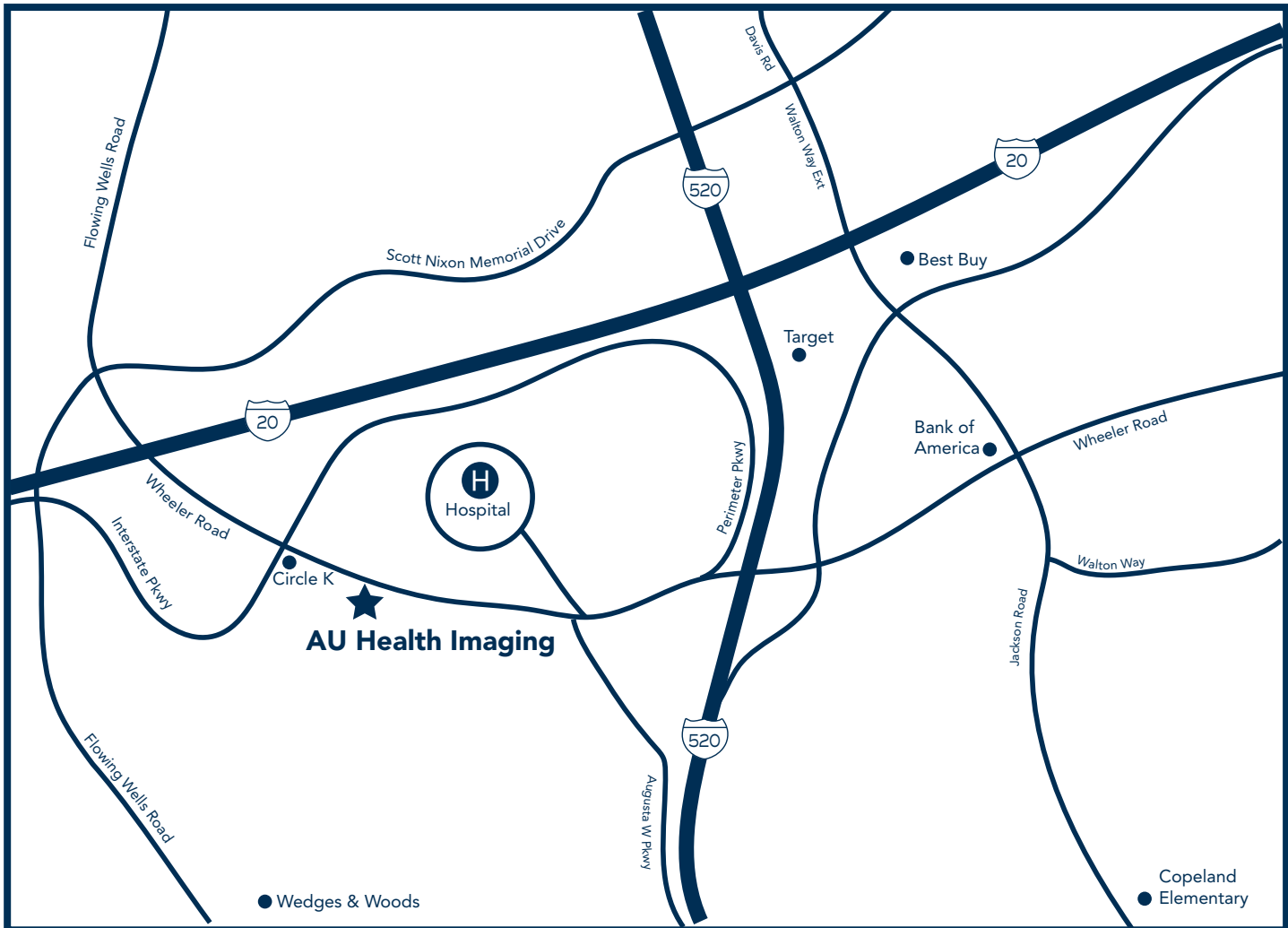


Imaging

AUGUSTA UNIVERSITY HEALTH

RADIOLOGY REFERRAL FORM

Scheduling: Phone: (706) 723-8860 Fax: (706) 723-8861
 3722 Wheeler Road, Augusta, GA 30909
 NPI: 1487285193 Tax ID: 84-4287604



Services / Hours

MRI.....	Monday - Friday	8:00am - 5:00pm
CT.....	Monday - Friday	8:00am - 5:00pm
Mammography.....	Monday - Friday	8:00am - 5:00pm
Ultrasound.....	Monday - Friday	8:00am - 5:00pm
Bone Density.....	Monday - Friday	8:00am - 5:00pm
X-ray.....	Monday - Friday	8:00am - 5:00pm

Pre-Authorization Service

For pre-authorization service, please submit the following with this order:

- Clinical Notes
- Treatment within 6 months
- Dates of previous visits
- Insurance Information
- Labs
- Medications
- Previous Imaging

Online Resources

Visit our website for more information on:

- Out of Pocket Cost: Our online estimator provides cost information for both insured and uninsured patients.
- Exam Preparation: Find information about how to prepare for the specific exam scheduled.
- Contact Information: Contact us with questions or to request an appointment through our online forms.