COMPASS HEALTH

SETTING A NEW DIRECTION IN HEALTH CARE

PHONE: (517) 999-5900
FAX: (517) 999-5901

CT REQUISITION FORM

Patients Name:		Date of Birth:	Pt. Weight(max 400#):
Insurance:	Precertification #:		Contract #:
Patient's Telephone #:		Name/Relationship of contact if not patient:	
Urgency of Exam: STAT (emergent/call report) ASAP (within 24 hrs.) Pt Convenience Approx. Date:_____			
PLEASE ATTACH A COPY OF THE PATIENTS INSURANCE CARD AND PRECERTIFICATION VERIFICATION.			
Blood Work (if applicable)	BUN:	Creatinine:	GFR:
Is patient taking Metformin?		Allergies:	
Criteria for blood work: (MUST BE WITHIN 30 DAYS OF EXAM DATE). • IS OVER AGE OF 60 • HAS HAD KIDNEY SURGERY • HAS HAD KIDNEY TRANSPLANT • HAS ONLY ONE KIDNEY • HAS DIABETES • HAS KIDNEY DISEASE		**IF PATIENT HAS AN ALLERGY TO IODINE PLEASE ORDER APPROPRIATE PRE-MEDICATION.** **IF PATIENT IS CURRENTLY TAKING METFORMIN AND REQUIRES CONTRAST, PATIENT MUST DISCONTINUE USE OF THIS MEDICATION FOR 2 DAYS FOLLOWING THE DATE OF THE EXAM & MAY REQUIRE FOLLOW UP LAB WORK.**	
Diagnosis (Reason for Exam) and ICD-9 ***(DO NOT USE RULE OUT FOR DX)*** :			
Clinical Information / Symptoms/ Rule Out:			
Physician's Name:		Physician Signature:	
Physician's Phone #:		Fax #:	

CIRCLE ALL THAT APPLY BELOW

CONTRAST	**IV**	W/O	WITH/WO	WITH	AS NEEDED		
	ORAL	REDI CAT	GASTROVIEW	NONE			
HEAD/NECK	HEAD	ORBITS	TEMPORAL BONES	FACIAL BONES	SINUSES	SOFT TISSUE	
CHEST	CHEST	PULMONARY EMBOLISM	HIGH RESOLUTION				
ABDOMEN/PELVIS	ABD/PELVIS	3 PHASE RENAL		RENAL STONE PROTOCOL			
SPINE	CERVICAL	THORACIC	LUMBAR	POST MYELOGRAM			
EXTREMITY	**RIGHT**	**LEFT**	**UPPER**	**LOWER**			
	SHOULDER	HUMEROUS	ELBOW	FOREARM	WRIST	HAND	FOOT
	TIB/FIB	CALCANEOUS	KNEE	FEMUR	HIP	ANKLE	