UW Health

ORDER FOR RADIOLOGY EXAM/PROCEDURE

This form is needed to order an exam/procedure in Radiology.
The form is for use by referring physicians.

Date: _____

EPIC/UWHC# (if known): _____

Index to Imaging Request

UW Health **www.uwhealth.org**
(University of Wisconsin Hospitals and Clinics Authority)

This form may be used to order a Radiology exam/procedure to be performed in any UW Health adult or pediatric Radiology site.

Fax completed form to: 608-662-4583 Toll Free: 844-662-4583

Thank you for referring your patient to UW Health. Please complete and submit the form below to begin the Radiology appointment request process. Please let your patient know about this Radiology order as we may need to contact the patient directly for information.

After submitting this order, a member of our staff will contact you within one to two business days with appointment details or to request additional information. If you'd prefer to call us, the phone numbers are listed below. Please allow one to two business days before calling.

Please indicate below if you have an appointment location preference.

☐ UWMF **608-287-2050** (includes 1 So. Park, HERI, WIMR, Odana Atrium, Yahara, Union Corners, Deforest/Windsor)

☐ UWHC **608-263-9729** (includes The American Center, University Hospital, Research Park, Digestive Health Center, East/West Clinics)

Please enter information in each field. ***Required fields**

Patient Information *(or include a copy of patient's demographic and insurance information)*

*First Name: _____ Middle Name: _____ *Last Name: _____

*Date of Birth (mm/dd/yyyy): _____ *Gender: ☐ Male ☐ Female

*Address: _____ *City: _____ *State: _____ *Zip: _____

Parent's Name (if a minor): _____ Guardian or Representative (if any): _____

Interpreter: □ Yes □ No Language: _____

*Preferred Phone#: _____ Phone Type: ☐ Home ☐ Work ☐ Cell

Alternative Phone#: _____ Phone Type: ☐ Home ☐ Work ☐ Cell

Email address: _____

Additional Contact Instructions (best time to reach, dates unavailable for appointment, etc.): _____

Patient Insurance Information

*Name of Insurance (if no insurance, indicate none): _____

Subscriber Name: _____ Subscriber ID: _____ Member ID: _____

Effective From Date: _____ Group Number: _____

Referring Physician Information

*Referring Provider: _____ Primary Care Physician (if different than referring): _____

*Clinic Name: _____

*Clinic Contact Name: _____ *Clinic Contact's Direct Number: _____

*Clinic Address: _____ *City: _____ *State: _____ *Zip: _____

*Telephone Number: _____ *Fax Number: _____

***Radiology Modality Type Requested** (check one below)

☐ BMD ☐ Breast Imaging ☐ CT ☐ Diagnostic Radiology ☐ GI/GU ☐ Interventional Radiology ☐ MRI ☐ Nuc Med

☐ PET ☐ Ultrasound *Specific Study needed: _____

Information needed for Radiology Order

*Diagnosis: _____ *ICD-10: _____

*What specific questions would you like answered by this exam?: _____

_____

*Who should we contact to coordinate scheduling an appointment? (check one): ☐ Referring Clinic ☐ Patient

☐ Permission to change request/type of order per Radiologist/protocol.

☐ Permission to include/exclude contrast media usage per Radiologist/protocol.

The signature below and transmission of this Order for Care certifies that he/she: (1) is a licensed health care professional with the authority and expertise to order the care specified herein; (2) has evaluated the patient identified herein and asserts that the care specified herein is medically necessary and ordered; and (3) UW Health may rely upon this Order for Care for all purposes, including without limitation billing third party payers.

Signature: _____ Date: _____ Time: _____