Patient Name

DOB:

MR #

Index to Imaging Request

Date:_____

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

RADIOLOGY EXAM/PROCEDURE ORDER

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

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 and/or 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

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, American Family Children's Hospital)

Patient Information *(Or please include a Facesheet)*

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

Patient Insurance Information

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

Member ID: _____

Referring Provider Information

Referring Provider: _____

Clinic Contact Name and telephone #:_____

Clinic Address:_____
(Street) (City) (State) (Zip)

Fax Number: _____

Comments:_____

_____

_____

□ 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: _____