McLaren
NORTHERN MICHIGAN

McLaren Northern Michigan Nuclear Medicine Order Form

Patient's Name Last: First: MI:	**Date of Birth**	☐ Male ☐ Female
Patient's Address Street: City: State: Zip:		
Insurance Information	**Patient's Phone** Daytime Phone: Cell:	
Patient's Height / **Patient's Weight**	**Study to be performed at:** ☐ Petoskey Campus	

Medical Necessity: Federal regulations require that only tests that are necessary for diagnosis and treatment of a patient's condition be ordered. ICD-10 Code and clinical history for each test is required to prove medical necessity.

We would like to remind providers that we cannot accept a diagnosis that includes the terms "PROBABLE", "POSSIBLE", "SUSPECTED", "RULE OUT", or "QUESTIONABLE".

Authorization number(s) if required:

_____

_____

Pre-Screening

Is there any chance that the patient is pregnant?	Y ☐ N ☐
Is the patient diabetic?	Y ☐ N ☐
Is there history of kidney problems?	Y ☐ N ☐
Does patient have pacemaker or defibrillator?	Y ☐ N ☐
Possibility of metal in eyes? **If yes to metal in eyes, please check box at bottom right for "Pre-MRI Orbit X-rays"**	Y ☐ N ☐
High Blood Pressure?	Y ☐ N ☐

List Allergies:

Procedure Date and Time:

Please Complete/Print/Sign and Fax to Central Scheduling: Fax# 231.487.7920-Tel# 231.487.3100-Toll Free# 866.487-3100

Reason/Signs and Symptoms for exam: _____

Diagnosis Code(s) for exam (ICD-10):_____

Special Instructions:_____

☐ ☐ Priority Reading to Dolbey ☐ Call STAT Report to: ☐ Send CD with Patient ☐

ABDOMINAL	**CPT#**	**THYROID**	**CPT#**	**SKELETAL**	**CPT#**
☐ HIDA/ Biliary EF w/cck		☐ Thyroid Uptake & Scan		☐ Bone Imaging Limited	78300
☐ Gastric Emptying		☐ Parathyroid Scan		☐ Bone Imaging Whole Body	
☐ GI Bleed		☐ Neck and Chest / Total Body I-131		☐ Bone Marrow Imaging Lmt Area	
☐ Liver Hemangioma		☐		☐ Bone Spect	
☐ Liver / Spleen Scan		☐		☐ Bone Three Phase	
☐ Meckel's Diverticulum		☐		Area of Focus:	
TUMOR		**CARDIAC**		**CEREBROSPINAL**	
☐ Gallium Tumor Localization		☐ MUGA/ Gated Blood Pool Rest		☐ Cisternogram	
☐ Lymphoscintigraphy/ Breast		☐ Myocardial Perfusion Rest/Stress			
☐ Lymphoscintigraphy/ Melanoma		☐ Treadmill ☐Pharmalogical			
☐ Octreoscan (Neuroendocrine)					
☐ Oncoscint (Colon or Ovarian CA)					
☐ Prostascint					
☐ Scintimammography (Miraluma)					
RENAL		**THERAPY**		**LUNG**	
☐ Renogram		☐ Thyroid Ablation / Cancer I-131		☐ Lung Ventilation/Perfusion (VQ)	
☐ Renogram GRF		☐ Thyroid Ablation /Hyperthyroid I-131		☐ Lung Quantitative	
☐ Renogram w/Captopril (Ace Inhibitor)		☐		☐ Perform Chest X-Ray if Needed	
☐ Renogram w/Lasix		☐			
INFECTION					
☐ Gallium Infection					
☐ WBC Ceretec Labeled Leukocytes					
☐ WBC Indium-111 Labeled Leukocytes					

Form filled out by:_____ Office Phone Number:_____

Ordering Physician:_____ Today's Date/Time:_____

Physician's Signature:_____(Sign after printing)