DENVER HEALTH

To whom it may concern,

To refer a patient for imaging at Denver Health please fully fill out our External Order Form faxed along with this cover page. If an imaging order comes to us not on this new External Order Form, we will fax our form back to be filled out before any order processing can take place.

Our new External Order Form captures all necessary information we need to properly and efficiently place imaging order(s).

Thank you,

Anna Davis, MHA

Sr. Administrative Director

Department of Radiology

Denver Health

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DENVER HEALTH
est. 1860
FOR LIFE'S JOURNEY

DENVER HEALTH RADIOLOGY
EXTERNAL ORDER FORM

777 Bannock St., Denver, CO 80204-4507
303-436-4949(P) 303-602-4168(F)
https://www.denverhealth.org/services/radiology

If you are referring a patient for Breast Imaging/Mammography services, please email breastimaging@dhha.org

Patient's Legal Name _____ Date of Birth _____ MR# _____
Print Last Name, First Name mm/dd/yyyy

Address _____ City _____ State _____ Zip Code _____ Phone _____

Pregnant: ☐ Yes ☐ No ☐ Unknown

Specific pertinent clinical history and indication: _____

CT Exam(s)

- ☐ CT Head Without Contrast
- ☐ CT Head And Cervical-Spine Without Contrast
- ☐ CT Face Without Contrast
- ☐ CTA Head With Contrast
- ☐ CTA Neck With Contrast
- ☐ CTA Head and Neck With Contrast
- ☐ CT Chest: ☐ PE ☐ With ☐ Without ☐ CTA
- ☐ CT Abdomen Pelvis: ☐ With ☐ Without (KUB) ☐ CTA
- ☐ CT Chest Abdomen Pelvis With Contrast: ☐ Trauma ☐ Routine
  CTA CAP: ☐ Dissection ☐ Aorta ☐ Pre-Graft ☐ Post-Graft
- ☐ CTA Upper Extremity ☐ CTA Lower Extremity Run-Off
- ☐ Other: _____ Contrast: ☐ Without ☐ With & Without ☐ With

Xray/Fluoroscopy/DEXA Exam(s)

- ☐ XR Chest: ☐ Frontal ☐ Lateral
- ☐ XR Abdomen: ☐ 1 View ☐ 2 Views ☐ 3 views
- ☐ XR Spine: ☐ Cervical ☐ Thoracic ☐ Lumbar
- ☐ XR Shoulder: ☐ Left ☐ Right ☐ Bilateral
- ☐ XR Humerus: ☐ Left ☐ Right ☐ Bilateral
- ☐ XR Elbow: ☐ Left ☐ Right ☐ Bilateral
- ☐ XR Forearm: ☐ Left ☐ Right ☐ Bilateral
- ☐ XR Wrist: ☐ Left ☐ Right ☐ Bilateral
- ☐ XR Hand: ☐ Left ☐ Right ☐ Bilateral
- ☐ XR Finger: ☐ Left ☐ Right ☐ Digit #: _____
- ☐ Fluoroscopy Modified Barium Swallow W/ Speech Pathology
- ☐ Fluoroscopy Esophagram
- ☐ XR Pelvis: ☐ Frontal ☐ Judet ☐ Obliques
- ☐ XR Hip: ☐ Left ☐ Right ☐ Bilateral
- ☐ XR Femur: ☐ Left ☐ Right ☐ Bilateral
- ☐ XR Knee: ☐ Left ☐ Right ☐ Bilateral ☐ Sunrise
- ☐ XR Tib/Fib: ☐ Left ☐ Right ☐ Bilateral
- ☐ XR Ankle: ☐ Left ☐ Right ☐ Bilateral ☐ Stress
- ☐ XR Foot: ☐ Left ☐ Right ☐ Bilateral ☐ Standing
- ☐ XR Toe: ☐ Left ☐ Right ☐ Digit #: _____
- ☐ Dexa Axial (Hip, Pelvis, Spine)
- ☐ Dexa Peripheral (Radius, Wrist, Heel)
- ☐ Other:

MRI Exam(s)

- ☐ MRI Brain: ☐ Without ☐ With & Without ☐ With
- ☐ MRI Cervical Spine: ☐ Without ☐ With & Without ☐ With
- ☐ MRI Thoracic Spine: ☐ Without ☐ With & Without ☐ With
- ☐ MRI Lumbar Spine: ☐ Without ☐ With & Without ☐ With
- ☐ MRI Shoulder: ☐ Left ☐ Right ☐ Without ☐ With & Without
  MRI Elbow: ☐ Left ☐ Right ☐ Without ☐ With & Without
  MRI Wrist/Hand: ☐ Left ☐ Right ☐ Without ☐ With & Without
- ☐ MRI Hip: ☐ Left ☐ Right ☐ Bilateral ☐ Without ☐ With & Without
- ☐ MRI Knee: ☐ Left ☐ Right ☐ Bilateral
- ☐ MRI Foot: ☐ Left ☐ Right ☐ Bilateral
- ☐ MRI Ankle: ☐ Left ☐ Right ☐ Bilateral
- ☐ MRI Abdomen: ☐ Without ☐ With & Without
- ☐ MRI Pelvis: ☐ Without ☐ With & Without
- ☐ Other: _____

Contrast: ☐ Without ☐ With & Without ☐ With

US Exam(s)

- ☐ US Thyroid
- ☐ US Abdomen: ☐ Complete ☐ RUQ ☐ Gall Bladder
- ☐ US Abdominal Wall
- ☐ US Renal Complete
- ☐ US Liver: ☐ Routine ☐ Doppler ☐ Elastography
- ☐ US Soft Tissue: (Area) _____
- ☐ US Pelvis Non-OB Complete Transabdominal and Transvaginal
- ☐ US OB Early Pregnancy Transabdominal And Transvaginal US
- ☐ Lower Extremity Venous With Doppler: ☐ Left ☐ Right ☐ Bilateral
- ☐ US Lower Extremity Venous With Doppler: ☐ Left ☐ Right ☐ Bilateral
- ☐ US Scrotum And Testicles With Doppler
- ☐ Other:

PET & NUCMED Exam(s)

- ☐ NM Bone Imaging Whole Body
- ☐ NM Thyroid Uptake And Imaging
- ☐ NM Lung Ventilation/Perfusion Aerosol (VQ Scan)
- ☐ NM Gastric Emptying
- ☐ NM Lymphoscintigram
- ☐ Other:
- ☐ Stress Test, Vasodilator Nuclear Stress Test
- ☐ NM Myocradial Perfusion SPECT With Eject Fract Stress And Rest
- ☐ NM Hepatobiliary With CCK With Ejection Fraction
- ☐ PET/CT Skull Base To Mid Thigh FDG
- ☐ PET/CT Whole Body FDG

Please Provide Supporting ICD-10 Codes & Diagnosis: _____

REFERRING PHYSICIAN INFORMATION:

Name _____ NPI # _____ CO. License # _____

Address _____ City/State _____ Zip Code _____

Telephone _____ Fax _____ Email _____

Ordering Provider Signature Date (mm/dd/yy)