DENVER HEALTH
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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)