



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 _____

Insurance Information: Payor Name: _____ Group #: _____ ID#: _____ Active? Yes No

Pregnant: Yes No Unknown

Specific pertinent clinical history and indication:

CT Exam(s)

- | | |
|--|--|
| <input type="checkbox"/> CT Head Without Contrast | <input type="checkbox"/> CT Chest: <input type="checkbox"/> PE <input type="checkbox"/> With <input type="checkbox"/> Without <input type="checkbox"/> CTA |
| <input type="checkbox"/> CT Head And Cervical-Spine Without Contrast | <input type="checkbox"/> CT Abdomen Pelvis: <input type="checkbox"/> With <input type="checkbox"/> Without (KUB) <input type="checkbox"/> CTA |
| <input type="checkbox"/> CT Face Without Contrast | <input type="checkbox"/> CT Chest Abdomen Pelvis With Contrast: <input type="checkbox"/> Trauma <input type="checkbox"/> Routine |
| <input type="checkbox"/> CTA Head With Contrast | CTA CAP: <input type="checkbox"/> Dissection <input type="checkbox"/> Aorta <input type="checkbox"/> Pre-Graft <input type="checkbox"/> Post-Graft |
| <input type="checkbox"/> CTA Neck With Contrast | <input type="checkbox"/> CTA Upper Extremity <input type="checkbox"/> CTA Lower Extremity Run-Off |
| <input type="checkbox"/> CTA Head and Neck With Contrast | <input type="checkbox"/> Other: _____ Contrast: <input type="checkbox"/> Without <input type="checkbox"/> With & Without <input type="checkbox"/> With |

Xray/Fluoroscopy/DEXA Exam(s)

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

MRI Exam(s)

- | | |
|--|--|
| <input type="checkbox"/> MRI Brain: <input type="checkbox"/> Without <input type="checkbox"/> With & Without <input type="checkbox"/> With | <input type="checkbox"/> MRI Hip: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> Without <input type="checkbox"/> With & Without |
| <input type="checkbox"/> MRI Cervical Spine: <input type="checkbox"/> Without <input type="checkbox"/> With & Without <input type="checkbox"/> With | <input type="checkbox"/> MRI Knee: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral |
| <input type="checkbox"/> MRI Thoracic Spine: <input type="checkbox"/> Without <input type="checkbox"/> With & Without <input type="checkbox"/> With | <input type="checkbox"/> MRI Foot: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral |
| <input type="checkbox"/> MRI Lumbar Spine: <input type="checkbox"/> Without <input type="checkbox"/> With & Without <input type="checkbox"/> With | <input type="checkbox"/> MRI Ankle: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral |
| <input type="checkbox"/> MRI Shoulder: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Without <input type="checkbox"/> With & Without | <input type="checkbox"/> MRI Abdomen: <input type="checkbox"/> Without <input type="checkbox"/> With & Without |
| MRI Elbow: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Without <input type="checkbox"/> With & Without | <input type="checkbox"/> MRI Pelvis: <input type="checkbox"/> Without <input type="checkbox"/> With & Without |
| MRI Wrist/Hand: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Without <input type="checkbox"/> With & Without | <input type="checkbox"/> Other: _____ |
| | Contrast: <input type="checkbox"/> Without <input type="checkbox"/> With & Without <input type="checkbox"/> With |

US Exam(s)

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

PET & NUCMED Exam(s)

- | | |
|--|---|
| <input type="checkbox"/> NM Bone Imaging Whole Body | <input type="checkbox"/> Stress Test, Vasodilator Nuclear Stress Test |
| <input type="checkbox"/> NM Thyroid Uptake And Imaging | <input type="checkbox"/> NM Myocardial Perfusion SPECT With Eject Fract Stress And Rest |
| <input type="checkbox"/> NM Lung Ventilation/Perfusion Aerosol (VQ Scan) | <input type="checkbox"/> NM Hepatobiliary With CCK With Ejection Fraction |
| <input type="checkbox"/> NM Gastric Emptying | <input type="checkbox"/> PET/CT Skull Base To Mid Thigh FDG |
| <input type="checkbox"/> NM Lymphoscintigram | <input type="checkbox"/> PET/CT Whole Body FDG |
| <input type="checkbox"/> Other: _____ | |

Please Provide Supporting ICD-10 Codes & Diagnosis: _____

REFERRING PHYSICIAN INFORMATION:

Name _____ NPI # _____ CO. License # _____
Address _____ City/State _____ Zip Code _____
Telephone _____ Fax _____ Email _____

