



DT18123



Children'sSM
Healthcare of Atlanta

STAT CALL REPORT

Advanced Pediatric Imaging

- Egleston**
1405 Clifton Road
Atlanta, GA 30322
404-785-6078
FAX: 404-785-9082
- Scottish Rite**
1001 Johnson Ferry Road
Atlanta, GA 30342
404-785-2787
FAX: 404-785-9062
- Webb Bridge**
3155 North Point Pkwy,
Alpharetta, GA 30005
404-785-9729
FAX: 404-785-9175
- Town Center**
625 Big Shanty Road,
Kennesaw, GA 30005
404-785-9729
FAX: 404-785-9175
- *Hughes Spalding (CT only)**
35 Jesse Hill Jr. Drive SE,
Atlanta, GA 30303
404-785-9988
FAX: 404-785-9972

ALL AREAS BELOW IN BOLD ARE REQUIRED

Patient's FULL LEGAL Name: _____ **DOB:** _____ **Home Phone:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Guarantor E-mail: _____ **Cell Phone:** _____
Insurance/Medicaid Plan: _____ **Policy & Group #:** _____
Authorization#: _____ (Please also fax copy of Insurance card, front & back, with this order)
Reason For Exam (Signs, Symptoms, Chief Complaint): _____
DIAGNOSIS CODE (Need ICD-10, Description): _____

REQUIRED

Ordering Physician's Signature ****Please be sure to include Clinical Notes****

Print MD Name: _____
Date/Time Signed: _____

Office Contact: _____
Practice Phone: _____
Backline Phone: _____
Fax: _____
PCP Fax: _____

PCP Name (if different): _____

Special Instructions

- Send CD with patient
- Schedule for (date/time): _____

Order Comments / Research Patient / Other?

SEDATION QUESTIONNAIRE

- Developmental Delay? No Yes History of apnea or obstructive breathing (e.g. snoring)? No Yes
- Does this child require General Anesthesia? No Yes Previous complication with sedation? No Yes

PET

- Sedation Possible (<10yr)
- PET CT Whole Body PET CT Whole Body Gallium Dotatate PET CT Brain Other

MRI Orders

- | | | |
|---|---|--|
| <p>Contrast at Radiologist's Discretion <input type="checkbox"/></p> <ul style="list-style-type: none"> <input type="checkbox"/> Brain <input type="checkbox"/> Brain Limited <input type="checkbox"/> Epilepsy Surgery <input type="checkbox"/> MRS (Spectroscopy) <input type="checkbox"/> Perfusion <input type="checkbox"/> Functional MRI <input type="checkbox"/> Brain/Orbits <input type="checkbox"/> IAC/Temporal Bones <input type="checkbox"/> Orbit <input type="checkbox"/> Face <input type="checkbox"/> Neck | <p>Without Contrast <input type="checkbox"/></p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest <input type="checkbox"/> Heart <input type="checkbox"/> Heart with Stress <input type="checkbox"/> Heart Velocity Flow Mapping (Cardiac) <input type="checkbox"/> Heart Iron Quantification <input type="checkbox"/> Abdomen <input type="checkbox"/> Elastography <input type="checkbox"/> Fetal <input type="checkbox"/> Ferriscan <input type="checkbox"/> Abdomen/Pelvis <input type="checkbox"/> Pelvis <input type="checkbox"/> Enterography <input type="checkbox"/> Lower Extremity (Femur/TibFib/Foot) Left/Right <input type="checkbox"/> Lower Extremity Joint (Knee/Ankle) Left/Right | <p>With & Without Contrast <input type="checkbox"/></p> <ul style="list-style-type: none"> <input type="checkbox"/> Urography <input type="checkbox"/> Pelvis/Hip <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Complete Spine <input type="checkbox"/> Complete Spine with Contrast <input type="checkbox"/> Brachial Plex without (Neuro) <input type="checkbox"/> Brachial Plex without (Ortho) <input type="checkbox"/> Arthrograms (WB/TC Only) <input type="checkbox"/> Left/Right <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Hip |
|---|---|--|
- Upper Extremity (Humerus/Ulna/Radius/Hand) Left/Right
- Upper Extremity Joint (Shoulder/Elbow/Wrist) Left/Right
- Whole Body
- MRA:** Brain / Neck / Chest / Abdomen / Pelvis / Extremity (upper/lower) _____ / Other _____
- MRV:** Brain / Neck / Chest / Abdomen / Pelvis / Extremity (upper/lower) _____ / Other _____

CT

- | | | | |
|---|--|---|---|
| <p><input type="radio"/> Contrast at Radiologist's Discretion</p> <ul style="list-style-type: none"> <input type="checkbox"/> Head <input type="checkbox"/> Orbit <input type="checkbox"/> Sella <input type="checkbox"/> Ear <input type="checkbox"/> Maxillofacial / Sinus <input type="checkbox"/> Neck <input type="checkbox"/> Sinus CT Pre-Surgical | <p><input type="radio"/> Without Contrast</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> T / L Spine | <p><input type="radio"/> With Contrast</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Abdomen /Pelvis <input type="checkbox"/> Pelvis <input type="checkbox"/> Limited Hip (Spica) | <p><input type="radio"/> Without & With Contrast</p> <ul style="list-style-type: none"> <input type="checkbox"/> Upper Extremity _____ L <input type="checkbox"/> R <input type="checkbox"/> Lower Extremity _____ L <input type="checkbox"/> R <input type="checkbox"/> 3D Rendering <input type="checkbox"/> Other _____ |
|---|--|---|---|
- CT Angiography:** Head Neck Chest Abdomen Abdomen/Pelvis

NUCLEAR MEDICINE (HOSPITAL ONLY)

- Sedation Possible (<8yr or Special Needs)
- Nuclear Cystogram
- Thyroid Scan w/Uptake-Multi (I-123)
- Thyroid Ablation
- HIDA with CCK
- Gastric Emptying Scan
- Meckels Scan
- GFR Height _____ Weight _____
- Kidney w/ Lasix (MAG3)
- Kidney w/o Lasix (MAG3)
- Kidney, Static (DMSA)
- Lung Scan Perfusion
- Lung Scan Ventil & Perfusion
- CSF Shunt Evaluation
- Brain Scan w/ SPECT
- Bone Scan w/ SPECT
- 3 Phase Bone Scan (specify area) _____
- DXA Bone Density
- MIBG Whole Body SPECT/CT
- Salivagram
- Liver/Spleen
- Other _____

Interventional Radiology and PET Order Forms available at <http://www.choa.org/Radiology>

Visit choa.org/radiology for a list of CPT codes, ACR ordering guidelines, or to request/print additional forms.