DT18123

Children's℠ Healthcare of Atlanta

☐ CALL REPORT _____

Advanced Pediatric Imaging

☐ Arthur M. Blank	☐ Scottish Rite	☐ Webb Bridge	☐ Town Center	☐ *Hughes Spalding (CT only)
2220 N Druid Hills Road NE Atlanta, GA 30329 404-785-2787 **FAX: 404-785-9082**	1001 Johnson Ferry Road Atlanta, GA 30342 404-785-2787 **FAX: 404-785-9062**	3155 North Point Pkwy, Building A, Suite 150 Alpharetta, GA 30005 404-785-9729 **FAX: 404-785-9175**	625 Big Shanty Road, Kennesaw, GA 30144 404-785-9729 **FAX: 404-785-9175**	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
******Please be sure to include Clinical Notes******

Ordering Physician's Signature: _____ **Office Contact:** _____
Print Physician Name: _____ **Practice Phone:** _____
Date/Time: _____ **Backline Phone:** _____
Fax: _____
PCP Name (if different): _____ **PCP Fax:** _____
Is the patient under foster care? _____

Special Instructions
☐ Send CD with patient
☐ Schedule for (date/time): _____

Order Comments / Research Patient / Other?

SEDATION QUESTIONNAIRE

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

MRI

Neuro
❑ Brain ❑ Sella
❑ Limited Ventricle Check
❑ Seizure Brain
❑ MRS (Spectroscopy)
❑ Perfusion
❑ Functional
❑ Brain & Optic Pathway
❑ Orbits ❑ Face ❑ Neck
❑ IAC/Mastoid
❑ Brachial Plexus
❑ C Spine ❑ T Spine ❑ L Spine

Body
❑ Abdomen
❑ Pelvis
❑ Abdomen & Pelvis
❑ Liver Elastography
❑ Enterography
❑ Urography
❑ Ferriscan
❑ Bone Marrow
❑ Whole Body (CNO/CRMO, Cancer Screening or Vascular Malformation)

Cardiac
❑ Chest
❑ Heart w/Stress
❑ Heart Velocity/ Flow Mapping
❑ Heart Iron Quantification

Fetal
❑ Neuro
❑ Body
❑ MRI Placenta

MSK

Upper Extremities
❑ Shoulder ☐ L ☐ R
❑ Clavicle ☐ L ☐ R
❑ Sternum ☐ L ☐ R
❑ Humerus ☐ L ☐ R
❑ Elbow ☐ L ☐ R
❑ Forearm ☐ L ☐ R
❑ Wrist ☐ L ☐ R
❑ Hand ☐ L ☐ R
❑ Finger ☐ L ☐ R
❑ Thumb ☐ L ☐ R
❑ Glenoid Dysplasia ☐ L ☐ R

Lower Extremities
❑ Pelvis ☐ L ☐ R
❑ Hip ☐ L ☐ R
❑ Femur ☐ L ☐ R
❑ Knee ☐ L ☐ R
❑ Tib/Fib ☐ L ☐ R
❑ Ankle/Hindfoot ☐ L ☐ R
❑ Whole Foot ☐ L ☐ R
❑ Midfoot ☐ L ☐ R
❑ Forefoot/Toes ☐ L ☐ R

Arthrograms
❑ Shoulder ☐ L ☐ R
❑ Knee ☐ L ☐ R
❑ Hip ☐ L ☐ R
❑ Wrist ☐ L ☐ R
❑ Elbow ☐ L ☐ R

MRA ❑ Head ❑ Neck ❑ Chest ❑ Abdomen ❑ Pelvis ❑ Entire Arm ❑ Entire Leg ❑ L ❑ R Other: _____
MRV ❑ Head ❑ Neck ❑ Chest ❑ Abdomen ❑ Pelvis ❑ Entire Arm ❑ Entire Leg ❑ L ❑ R Other: _____

❍ **With Contrast** ❍ **Without Contrast** ❍ **With & Without Contrast** ❍ **Radiologist Discretion**

PET (AMB ONLY)

❍ **Sedation Possible** (<10yr)
❑ PET CT Whole Body ❑ PET CT Whole Body Gallium Dotatate ❑ PET CT Brain ❑ Other

CT

❑ Head
❑ Orbit ❑ Sella ❑ Ear
❑ Maxillofacial / Sinus
❑ Neck
❑ Sinus CT Pre-Surgical

❑ Cervical Spine
❑ Thoracic Spine
❑ Lumbar Spine
❑ Pelvis

❑ Chest
❑ Abdomen
❑ Abdomen /Pelvis
❑ Limited Hip (Spica)

❑ Upper Extremity _____ ☐ L ☐ R
❑ Lower Extremity _____ ☐ L ☐ R
❑ 3D Rendering
❑ Other _____

CT Angiography: ❑ Head ❑ Neck ❑ Chest ❑ Abdomen ❑ Abdomen/Pelvis

❍ **With Contrast** ❍ **Without Contrast** ❍ **With & Without Contrast** ❍ **Radiologist Discretion**

NUCLEAR MEDICINE (HOSPITAL ONLY)

❍ **Sedation Possible** (<8yr or Special Needs)
❑ Nuclear Cystogram
❑ Thyroid Scan w/Uptake-Multi (I-123)
❑ Thyroid Ablation
❑ HIDA q with CCK
❑ Gastric Emptying Scan
❑ Meckels Scan
❑ Brain Scan w/ SPECT

❑ Kidney w/ Lasix (MAG3)
❑ Kidney w/o Lasix (MAG3)
❑ Kidney, Static (DMSA)
❑ Lung Scan Perfusion
❑ Lung Scan Ventil & Perfusion
❑ CSF Shunt Evaluation
❑ Other _____

❑ Bone Scan ❑ w/ SPECT
❑ 3 Phase Bone Scan (specify area) _____
❑ DXA Bone Density
❑ MIBG Whole Body SPECT/CT
❑ Salivagram
❑ Liver/Spleen

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