



DT18123



Children'sSM
Healthcare of Atlanta



Interventional Radiology

 Egleston

1405 Clifton Road
Atlanta, GA 30322
404-785-2079

FAX: 404-785-6209

 Scottish Rite

1001 Johnson Ferry Road
Atlanta, GA 30342
404-785-4775

FAX: 404-785-4713

ALL AREAS BELOW IN BOLD ARE REQUIRED

Patient's FULL LEGAL Name	Date of Birth	Phone Number
Address	City, State	ZIP
Insurance/Medicaid Plan	Policy & Group#	
Authorization# <i>(Please also fax a copy of insurance card, front and back, with this order)</i>	Guarantor's Email	
Reason For Exam <i>(Signs, Symptoms, Chief Complaint)</i>		
Exam to be Completed <i>(If procedure is a Lumbar Puncture, Please notate below if opening/closing pressures are necessary along with CSF samples or CSF samples alone.)</i>		
Lab Orders <i>(If any specimens are to go to the lab, please place Lab Orders below. If this section is not completed, no studies will be completed by the lab.)</i>		
ALL OFFICE CONTACT INFORMATION REQUESTED IS MANDATORY		
Ordering Physician's Printed Name	Practice Name	
Ordering Physician's Signature	Office Contact	
Date/Time Signed	Backline Phone	Fax
PCP Name (if different):	PCP Fax	

Interventional Radiology

<p>Special Instructions</p> <p>Date / Time Req: _____</p> <p>Confirmed Appt: _____</p> <p>Foster Child: <input type="checkbox"/> Yes</p> <p>Contact: _____</p>	<p>Order Comments / Other</p>
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[Visit choa.org/radiology](http://visit.choa.org/radiology) for a list of CPT codes, ACR ordering guidelines, or to request/print additional forms.