INSIGHT IMAGING

CT Order

Phone: 810-275-9688 Fax: 810-963-1900 www.iinn.com
4800 S. Saginaw Street – Suite 1650 – Flint, MI 48507

Date: _____ Prior Authorization Number: _____

Name: _____ DOB: _____ Age: _____ Sex: **M F**

Rule Out: _____ Diagnosis: _____ HT: _____ WT: _____

Referring Physician: _____

Are you allergic to Iodine, Shrimp, Shellfish? **Y N** Premedicated? **Y N** _____
Have you had a CT scan before with IV contrast? **Y N**
Have you had any previous testing done on the target area? **Y N** _____
Drug allergies: _____
Current medications: _____

CT Scans	**CTA Scans**
□ Abdomen □ Arm* R L □ Brain □ Cervical Spine* □ Chest □ Chest (high Res)* □ IAC's/Mastoids* □ Leg* R L □ Lumbar Spine* □ Pelvis □ Neck (soft/tissue) □ Orbits/Eyes* □ Renal Lithiasis* □ Sinuses* □ Thoracic Spine* □ Urogram	□ Aorta** □ Carotid Arteries** □ Chest (for PE)** □ Circle of Willis** □ Renal Arteries** □ Thoracic Aorta** □ Run-Off**
	□ Screening Chest CT
☐ w/o Contrast * CT Scans usually without contrast BUN/CR: _____	☐ w/Contrast (Requires BUN &CR) **CTA always done with IV contrast Date: _____

DOES PATIENT HAVE OR HAVE HAD ANY OF THE FOLLOWING?

Kidney Problem Explain:	Y	N	TB or other contagious diseases Explain:	Y	N	Cancer Type:	Y	N
Diabetes	Y	N	Stroke/ Mini Strokes	Y	N	Radiation/Chemo Treatment	Y	N
Heart Attack/ Failure	Y	N	Trauma to affected area	Y	N	Multiple Myeloma	Y	N
Smoker	Y	N	Abdomen/ Pelvic Surgeries	Y	N	Sickle Cell Anemia	Y	N
Asthma	Y	N	Diverticulitis/Crohn's/IBS	Y	N	Pregnant/Breast Feeding	Y	N
Hypertension	Y	N	Kidney Stones	Y	N	Aneurysm	Y	N
Seizures	Y	N	Lumps, Bumps, Masses	Y	N	Hernia	Y	N

PLEASE CIRCLE ALL SYMPTOMS YOU ARE HAVING:

Pain in Abdomen/Pelvis	Frequent UTI	Pain in Side	Pain in Lower Back
Numbness/Tingling in feet	Nausea	Swelling in Feet	Cold Feet
Blood in Urine	Blood in Stool	Diarrhea	Pain in Legs
Constipation	Bloating	Vomiting	Weight Loss
Difficulty/Pain when Urinating	Loss of Appetite	Burning/Tearing sensation in back of Abdomen	

Symptom Onset: _____
Please list any other surgeries or symptoms you may be having: _____

PREPARING FOR YOUR CT/CTA EXAM:

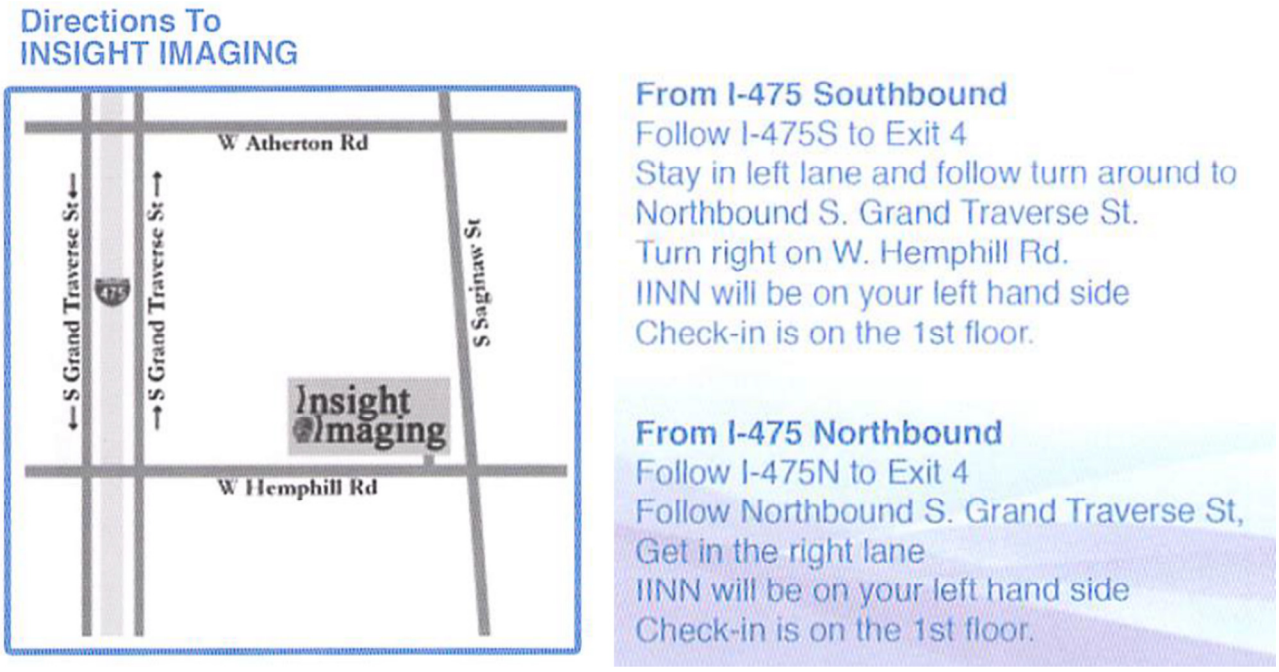
- Bring your prescription to the appointment
- Bring insurance cards and driver's license to your appointment
- Arrive 15 minutes prior to your appointment time to complete paperwork
- Please let us know if you are pregnant or breastfeeding
- You must have your insurance referral form and/or pre-authorization number if required
- Please give our office 24-hour notice if you cannot keep your appointment
- Call us anytime if you have questions
- Related radiographic/imaging studies should accompany patients

CT Scans and CTA (30-45 minute test)

- Please remove all metallic objects
- CT with contrast/CTA: No food or liquid 4 hours prior to your exam, may take medication with a small amount of water.
- CT abdomen: drink one bottle of oral barium 45 minutes prior to your exam
- CT abdomen and pelvis and CT pelvis: drink one bottle of oral barium 2 hours prior to your exam, drink second bottle of oral barium 30 minutes prior to your exam

Diabetic patients having contrast: Do not take any form of Metformin the morning of your test. You must remain off any type of Metformin 48 hours after your CT scan.

Iodine Allergy Prep: Take 40mg tablet(s) of Prednisone at bedtime the evening before your exam. Take 40 mg tablet(s) of Prednisone, and 50 mg of diphenhydramine (Benadryl) 2 hours prior to your exam.



*****Staff Use Only*****

Ordering Physician: _____ Phone: _____ Fax: _____

Contrast: W W/O W/WO Contrast Type: _____ Contrast Amount: _____ Lot#/Exp: _____

Bun/Creat: _____ Date Drawn: _____ Tech Signature: _____