

PATIENT INFORMATION

TODAY'S DATE _____

Patient Name:		DOB:
Patient Address:	Patient Phone:	
Indication for CT/ Diagnosis:	ICD-10:	
Is this STAT? <input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, Please provide CMP within 48 hours)		
Is the patient Diabetic? <input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, please provide blood labs within 6 weeks)		
Special Appointment Request:		

INSURANCE

NPI#: 14674406736 TIN#: 56-2179043 Authorization#: _____

Primary:	ID#:
Secondary:	ID#:

ORDER SPECIFICS - Types of CT Scan

<input type="checkbox"/> Chest	<input type="checkbox"/> Abdominal/Pelvis	<input type="checkbox"/> Abdominal	<input type="checkbox"/> BOTH IV & Oral Contrast	<input type="checkbox"/> WITH IV Contrast Only
<input type="checkbox"/> Head	<input type="checkbox"/> Neck-soft Tissue	<input type="checkbox"/> CT-PE Protocol	<input type="checkbox"/> WITH Oral Contrast	<input type="checkbox"/> NO IV or Oral Contrast
<input type="checkbox"/> Patients Getting Contrast , Most Recent Creatinine Levels:				

REFERRING PROVIDER INFORMATION

Office Contact:	Phone #:
Practice:	Imaging Report to Fax #:
Referring Provider:	Signature:
A radiologist report of the scan findings will be faxed to the number you indicated on this form	
Will you need the images? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If <input type="checkbox"/> YES, what is your Nuance PowerShare registered name:	

*** Please fax all pertinent progress notes, radiology reports, demographics, and insurance cards to Fax #: 704.377.0353 ***

CHARLOTTE

2711 Randolph Rd, Suite 400
Charlotte, NC 28207

Phone: 704.342.9577 • Fax: 704.377.0353

DISCOVER THE
DIFFERENCE
IN CANCER CARE

charlotte**CAN**cer.com