<table>
<thead>
<tr>
<th>High Field Wide-Bore MRI Centers</th>
<th>High Field MRI Centers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fairfield</td>
<td>Orange</td>
</tr>
<tr>
<td>1055 Post Rd. Fairfield, CT 06824</td>
<td>297 Boston Post Rd. Orange, CT 06477</td>
</tr>
<tr>
<td>Trumbull</td>
<td>Stamford</td>
</tr>
<tr>
<td>15 Corporate Dr. Trumbull, CT 06611</td>
<td>1259 East Main St. Stamford, CT 06902</td>
</tr>
<tr>
<td>Wilton</td>
<td>Shelton</td>
</tr>
<tr>
<td>30 Danbury Rd. Wilton, CT 06897</td>
<td>4 Corporate Dr. Shelton, CT 06484</td>
</tr>
<tr>
<td></td>
<td>Stratford</td>
</tr>
<tr>
<td></td>
<td>2876 Main St. Stratford, CT 06614</td>
</tr>
</tbody>
</table>

### Patient Information

- **Patient Name**: 
- **DOB**: 
- **Preferred Phone #**: 
- **Appt. Date/Time**: 
- **Insurance**: 
- **ID#**: 
- **Prev. Films**: 
- **Prior Auth Req.**: 
- **AFTER HRS/STAT CALL BACK #**: 

### Referring Practitioner

- **Name**: 
- **Phone #**: 

### Referring Signature

- **Date**
- **CC**: 

### MRI Request

<table>
<thead>
<tr>
<th>Without Contrast</th>
<th>With AND Without Contrast</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Lab Values for Contrast Exams**:
  - eGFR 
  - Lab: 
- **Date**: 

### Brain

- **Brain**: 
- **Spectroscopy**: 
- **NeuroQuant**: 
  - Brain w/ and w/o 
  - Brain w/o 
- **DTI**: 
  - Brain w/ and w/o 
  - Brain w/o 

### Head and Neck

- **Orbits**: 
- **Soft Tissue Neck/Parotid**: 
- **Brachial Plexus**: Right 
  - Left 
- **Other**: Please specify 

### Spine

- **Cervical Spine**: 
- **Thoracic Spine**: 
- **Lumbar Spine**: 
- **Total Spine Series**: 
- **Lumbosacral Plexus**: 

### Body

- **Abdomen**: Please specify 
- **Chest**: Please specify 
- **Pelvis**: Please specify 
- **MRCP**: 
- **Prostate**: (3T Preferred) 
- **Enterography**: w/ and w/o contrast 

### Musculoskeletal System

- **ARTHROGRAM REQUESTED**:
  - Shoulder: Right 
  - Left 
  - Elbow: Right 
  - Left 
  - Wrist: Right 
  - Left 
  - Hand: Right 
  - Left 
  - Fingers: Right 
  - Left 
  - Hip: Right 
  - Left 
  - Knee: Right 
  - Left 
  - Ankle: Right 
  - Left 
  - Forefoot: Right 
  - Left 
  - Midfoot: Right 
  - Left 
  - Hindfoot: Right 
  - Left 
  - Upper Extremity Other Than Joint: Right 
  - Left 

### Other

- **(Please specify body part)**
  - **Lower Extremity Other Than Joint**: Right 
  - Left 

### Please Check If Applicable

<table>
<thead>
<tr>
<th>MRI Type</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bilateral MRI</td>
<td></td>
</tr>
<tr>
<td><strong>MRA Studies</strong></td>
<td></td>
</tr>
<tr>
<td>Head: Circle of Willis</td>
<td></td>
</tr>
<tr>
<td>(High Field Preferred)</td>
<td></td>
</tr>
<tr>
<td>MRV Head</td>
<td></td>
</tr>
<tr>
<td>Neck: Carotid w/ w/o</td>
<td></td>
</tr>
<tr>
<td>Preferred</td>
<td></td>
</tr>
<tr>
<td>Chest</td>
<td></td>
</tr>
<tr>
<td>Renal</td>
<td></td>
</tr>
<tr>
<td>Run-Off</td>
<td></td>
</tr>
<tr>
<td>Other: Please specify</td>
<td></td>
</tr>
</tbody>
</table>

### Please Check If Applicable

- **Acute Stroke**: MS 
- **Cranial Nerve**: Myelopathy 
- **Seizure**: Acute Trauma 
- **Pituitary**: Metastasis 
- **IAC / Post Fossa**: Compression Fracture 
- **NPH / Dementia**: 

### Please Check If Applicable

- **(Please specify body part)**
  - **Lower Extremity Other Than Joint**: Right 
  - Left 

### Please Check If Applicable

- **(Please specify body part)**
  - **Other**: Please specify
Patient Name ____________________________

DOB ____________________________ Preferred Phone # ____________________________

Appt. Date/Time ____________________________

Insurance ____________________________

ID# ____________________________

Prev. Films ☐ No  ☐ Yes  Where? ____________________________

Prior Auth Req.?  ☐ No  ☐ Yes  Auth.# ____________________________

AFTER HRS/STAT CALL BACK # ____________________________

Details:

<table>
<thead>
<tr>
<th>Mammogram</th>
<th>Ultrasound</th>
<th>CT Scan</th>
<th>Nuclear Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Diagnostic: Trumbull, Stamford, Wilton ONLY</td>
<td>☐ Abdomen (liver, gallbladder, pancreas)</td>
<td>☐ Excluding Wilton and Orange</td>
<td>☐ Gallium</td>
</tr>
<tr>
<td>☐ Right  ☐ Left  ☐ Bilateral</td>
<td>☐ Aorta</td>
<td>☐ Brain</td>
<td>☐ Infection Imaging / WBC Scan</td>
</tr>
<tr>
<td>☐ 3D Screening: Excluding Orange</td>
<td>☐ Appendix</td>
<td>☐ Neck</td>
<td>☐ Prostascent</td>
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<tr>
<td>☐ Right  ☐ Left  ☐ Bilateral</td>
<td>☐ Kidneys (Renal)</td>
<td>☐ Orbits</td>
<td>☐ WBC and Marrow Scan</td>
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<tr>
<td>☐ Addtl: U/S if necessary</td>
<td>☐ Elastography (Liver)</td>
<td>☐ Temporal Bones</td>
<td>☐ Lung Scan (V/Q)</td>
</tr>
<tr>
<td>☐ DEXA: Trumbull, Stratford, Wilton ONLY</td>
<td>☐ Extremity (Non-vascular)</td>
<td>☐ Sinuses:  ☐ Full (Coronal and Axial)</td>
<td>☐ Gastric Emptying Study</td>
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<tr>
<td>☐ Breast Ultrasound</td>
<td>☐ Right  ☐ Left  ☐ Bilateral</td>
<td>☐ Limited</td>
<td>☐ MUGA Scan</td>
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<tr>
<td>☐ Diagnostic: Trumbull or Stamford ONLY</td>
<td>☐ Scrotum</td>
<td>☐ Spine:  ☐ 3D</td>
<td>☐ Parathyroid Scan</td>
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<tr>
<td>☐ Right  ☐ Left  ☐ Bilateral</td>
<td>☐ Thyroid</td>
<td>☐ Cervical</td>
<td>☐ Other: (Please specify)</td>
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<tr>
<td>☐ Screening: Excluding Orange</td>
<td>☐ Thyroid Biopsy</td>
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<tr>
<td>☐ Right  ☐ Left  ☐ Bilateral</td>
<td>☐ Thyroid FNA</td>
<td>☐ Lumbar</td>
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<tr>
<td>☐ Cyst Aspiration</td>
<td>☐ Pelvic:</td>
<td>☐ Chest:</td>
<td></td>
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<tr>
<td>☐ Needle Core Biopsy</td>
<td>☐ Transabdominal</td>
<td>☐ Chest</td>
<td>☐</td>
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<tr>
<td>☐ Diagnostic X-Ray</td>
<td>☐ Transvaginal</td>
<td>☐ CTPA Pulmonary Embolism Protocol</td>
<td>☐ Renal Scan:</td>
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<tr>
<td>☐ Skull</td>
<td>☐ Other: (Please specify)</td>
<td>☐ High Res (Interstitial Lung Disease)</td>
<td>☐ ☐ I - 123 (with uptake)</td>
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<tr>
<td>☐ Cervical Spine</td>
<td>☐ Intraoperative</td>
<td>☐ Lung Screen</td>
<td>☐ I - 131 Whole Body Scan</td>
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<tr>
<td>☐ Thoracic Spine</td>
<td>☐ Calcium Score:</td>
<td>☐ CTPA Pulmonary Embolism Protocol</td>
<td>☐ Therapy:</td>
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<tr>
<td>☐ Lumbar Spine</td>
<td>☐ Stamford, Shelton, Stratford, Trumbull ONLY</td>
<td>☐ High Res (Interstitial Lung Disease)</td>
<td>☐ ☐ I - 131</td>
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<tr>
<td>☐ Scoliosis Series: EXCL. Shelton, Orange</td>
<td>☐ Coronary CTA:</td>
<td>☐ Lumbar</td>
<td>☐ Other: (Please specify)</td>
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<td>☐ Sinuses</td>
<td>☐ Shelton ONLY</td>
<td>☐ Thoracic</td>
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<tr>
<td>☐ Chest</td>
<td>☐ Hematura Protocol</td>
<td>☐ Lumbar</td>
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<tr>
<td>☐ Rib</td>
<td>☐ Liver Mass Protocol</td>
<td>☐ Abdomen Only</td>
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<td>☐ IVP: Fairfield ONLY</td>
<td>☐ Abdomen and Pelvis</td>
<td>☐ Pelvis Only</td>
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<td>☐ Abdomen</td>
<td>☐ Volumes (CT Enterography)</td>
<td>☐ Urinary Stone Localization</td>
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<tr>
<td>☐ Pelvis</td>
<td>☐ Hematura Protocol</td>
<td>☐ Extremities</td>
<td></td>
</tr>
<tr>
<td>☐ Extremity: ☐ Right  ☐ Left</td>
<td>☐ Liver Mass Protocol</td>
<td>☐ Right  ☐ Left  ☐ 3D</td>
<td></td>
</tr>
<tr>
<td>☐ (Please specify body part)</td>
<td>☐ Abdomen Only</td>
<td>☐ AAA Protocol</td>
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<td>☐ Metastatic Series</td>
<td>☐ Pelvis Only</td>
<td>☐ CTA</td>
<td></td>
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<td>☐ Other: (Please specify)</td>
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<td>☐ Runoff</td>
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<td>☐ Fluoroscopy</td>
<td>☐ Extremities</td>
<td>☐ Other: (Please specify)</td>
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<td>☐ Trumbull ONLY</td>
<td>☐ Right  ☐ Left  ☐ 3D</td>
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<tr>
<td>☐ Upper GI Series</td>
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<td>☐ Small Bowel Series</td>
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<tr>
<td>☐ Esophagram</td>
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<tr>
<td>☐ Other: (Please specify)</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
### Patient Information

**Patient Name:**
- Male □ Female □ DOB __________________

**Preferred Phone #** __________________

**Appt. Date/Time** __________________

**AFTER HOURS/STAT CALL BACK #** __________________

**Primary Insurance/ID#** __________________

**Pre-Cert. Req.?** □ No □ Yes Pre-Cert.# __________________

**Secondary Insurance/ID#** __________________

**Pre-Cert. Req.?** □ No □ Yes Pre-Cert.# __________________

### Referring Practitioner

**Referring Practitioner (please print)**

**Name** __________________

**Phone #** __________________

**Referring Signature**

**Date** ____________  **CC:** __________________

### Patient’s Clinical History

**Patients’s Clinical History:**

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

**PET/CT Reason:**

**Cancer Type:** __________________

**Initial:**
- PET/Non-diagnostic Computed Tomography (CT) to inform the initial treatment strategy of tumors that are biopsy-proven or strongly suspected of being cancerous based on other diagnostic testing.

**Subsequent:**
- PET/Non-diagnostic Computed Tomography (CT) to inform the subsequent treatment strategy of cancerous tumors when the beneficiary’s treating physician determines that the PET study is needed to inform subsequent anti-tumor strategy.

**Is the patient diabetic?**
- □ Yes □ Type 1 □ Type 2 □ Unknown □ No

**Is the patient on insulin?**
- □ Yes □ What Type? __________________
  □ No

**Is the patient on metformin?**
- □ Yes □ No

**What is the patient’s morning glucose level?**

**Medication History**

- □ Recent Chemotherapy  **Date** __________________
- □ Radiation  **Date** __________________
- □ Prior Surgery  **Date** __________________ **Facility** __________________
- □ Prior Biopsy  **Date** __________________ **Facility** __________________
- □ Colony Stimulating Factor Therapy  **Date** __________________
- □ Steroid Use  **Date** __________________
- □ Neupogen  **Date** __________________
- □ Neulasta  **Date** __________________

### Patient’s Signs and Symptoms

**Patient’s Signs and Symptoms:**

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

**Where? Side of interest?**
- □ Right □ Left □ Bilateral □ RUQ □ LUQ □ RLQ □ LLQ □ N/A

**Of clinical importance: Rule out / History of / Question of:**

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

### ICD-10 Codes

**ICD-10 Codes:**

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

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**PLEASE NOTE:** All PET/CT studies are performed at 15 Corporate Drive, Trumbull, CT 06611.

Our PET/CT scanner uses non-diagnostic, low-dose CT for attenuation correction and anatomic localization.

All orders must be signed by the ordering practitioner. Copies of both sides of the patient’s insurance cards must be faxed with this order before an appointment can be scheduled. Advanced Radiology will contact the patient and physician after insurance confirmation to schedule the appointment and provide additional instructions.

- 78608 - Brain, Dementia (FDG / AMYVid)
- 78608 - Brain, Seizure
- 78815 - Skull to Mid-Thigh
- 78459 - Myocardial Viability
- 78815 - Pulmonary Nodule Evaluation
- 78814 - Limited
- 78816 - Whole Body (Melanoma)
- 78811 - 78816 (Carrier dependent) G0235 (Medicare) Infection / Inflammation (Vasculitis)
- Other: (Please specify)

---

**Tax ID #06-1614148**

Fax: 203.459.0116  Online: Orders.AdRad.com

Central Scheduling: 203.337.XRAY (9729)

Tax ID #06-1614148
### Patient Name

- Male
- Female

DOB __________________________

### Preferred Phone #

______________________________

### Appt. Date/Time

______________________________

### AFTER HOURS/STAT CALL BACK #

______________________________

### Primary Insurance/ID# ________________

Pre-Cert. Req.? □ No □ Yes Pre-Cert.# __________________________

### Secondary Insurance/ID# ________________

Pre-Cert. Req.? □ No □ Yes Pre-Cert.# __________________________

### Patients’s Clinical History:

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

### Patient’s Signs and Symptoms:

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

Where? Side of interest?

- Right
- Left
- Bilateral
- RUQ
- LUQ
- RLQ
- LLQ
- N/A

Of clinical importance: Rule out / History of / Question of:

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

### ICD-10 Codes:

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

### Exams / Special Instructions:

- Ambulatory Phlebectomy
- Biliary Tube Change
- Cyst Aspiration: Specify Body Part
- Epidural
- Endovenous Radiofrequency Ablation
- Interventional Oncology Consultation
- EVLT
- Liver Biopsy
- Lumbar Puncture
- Lymph Node Needle Biopsy
- Myelogram Lumbar
- Nephrosomy Tube Change
- PICC Placement
- PICC Removal
- Paracentesis
- Diagnostic
- Therapeutic
- Thoracentesis
- Diagnostic
- Therapeutic
- Thyroid Biopsy
- Thyroid FNA
- Tunneled CV Cath
- VCUG: Pediatric ONLY (under 24 months)

### Procedural Details / Additional Comments:

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________
The Centers for Medicare & Medicaid Services (CMS) has determined that the evidence is sufficient to add a lung cancer screening counseling and shared decision-making visit, and for appropriate beneficiaries, annual screening for lung cancer with low dose computed tomography (LDCT), as an additional preventive service benefit under the Medicare program only if all of the following criteria are met:

- Patient is between 55 and 77 years of age
- Patient is currently a smoker
- Patient has quit smoking for _____ years
- Patient has a minimum 30 pack/year smoking history:
  Packs/Day (20 cigarettes/pack) _____ X Years _____ = Pack Years _____
- The patient is asymptomatic (no signs or symptoms of lung cancer)

For Initial Lung Screenings: Beneficiary must receive a written order for LDCT lung cancer screening during a lung cancer screening counseling and shared decision making visit, furnished by a physician or qualified non-physician practitioner (physician assistant, nurse practitioner, or clinical nurse specialist)

For Subsequent/Annual Lung Screenings: Beneficiary must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner (physician assistant, nurse practitioner, or clinical nurse specialist)

A lung cancer screening counseling and shared decision-making visit must include the following, which must also be documented in the patient’s medical history:

- Determination of beneficiary eligibility including age, absence of signs or symptoms of lung cancer, a specific calculation of cigarette smoking pack-years; and if a former smoker, the number of years since quitting
- Shared decision making, including the use of one or more decision aids, to include benefits and harms of screening, follow-up diagnostic testing, over-diagnosis, false positive rate, and total radiation exposure
- Counseling on the importance of adherence to annual lung cancer LDCT screening, impact of comorbidities, and ability or willingness to undergo diagnosis and treatment
- Counseling on the importance of maintaining cigarette smoking abstinence if former smoker; or the importance of smoking cessation if current smoker and, if appropriate, furnishing of information about tobacco cessation interventions
- If appropriate, the furnishing of a written order for lung cancer screening with LDCT; Written orders for both initial and subsequent LDCT lung cancer screenings must contain the following, which must also be documented in the patient’s medical record:
  - Beneficiary’s date of birth
  - Actual pack/year smoking history number
  - Current smoking status and/or number of years since quitting
  - Confirmation that patient is asymptomatic
  - NPI of the referring practitioner
PREPARING FOR YOUR VISIT
When you schedule your appointment, you will receive information about any preparation that is specific to your exam. Please bring this prescription and arrive 15 minutes before your scheduled appointment. Late arrival may mean cancellation of your appointment. If you must cancel, please do so a minimum of 24 hours prior to your appointment time.

Please be sure to bring the following:

- Photo ID
- Insurance information: Please bring your insurance card or proof of insurance coverage. In order to bill your insurance carrier(s) for services rendered, we will need the name of the carrier (company), their complete mailing address, your policy’s group number, and your personal identification number. If you are covered by Medicare or Medicaid, please bring the appropriate card.
- Medications: Please bring a list of all medications and dosages, including all over the counter medicines you currently use.
- Prior Imaging: If you have had any relevant prior imaging performed anywhere other than Advanced Radiology, please bring the images to your appointment. This includes mammograms.
- Payment: You will be responsible for services not covered by insurance, including co-pays. Advanced Radiology accepts cash, check, or major credit card (MasterCard, Visa, or American Express).