

CT/MRI Order Form



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COMPUTED TOMOGRAPHY

W & W/O *Only if baseline renal/adrenal mass, hemorrhage or cryoablation zone.

Head (brain)	W	W/O	W & W/O		Cervical Spine	W	W/O	W & W/O		Abdomen	W	W/O	W & W/O	
Facial Bones	W	W/O	W & W/O		Thoracic Spine	W	W/O	W & W/O		Pelvis	W	W/O	W & W/O	
Orbits	W	W/O	W & W/O		Lumbar Spine	W	W/O	W & W/O		Renal Stone Protocol Abdomen/Pelvis W/O		W/O		
Temporal Bones/IAC	W	W/O			Thorax	W	W/O	W & W/O		CT Urogram (Abdomen/Pelvis)			W & W/O	
Sinus	W	W/O	W & W/O		High Resolution Chest		W/O			Extremity Upper: Specify R L	W	W/O	W & W/O	
Landmark Stealth		W/O			CT Lung Screening Consult	Email: screening@karmanos.org				Extremity Lower: Specify R L		W/O	W & W/O	
Maxillofacial	W	W/O	W & W/O		CT Thorax for Pulmonary Embolism (CTA)	W				CTA: Body Part (Circle) Abdomen, Abdomen/Pelvis, Neck, Head/Brain, Thorax Lower Extremity R, L, Abd Aorto IF Runoff Bilateral	W		W & W/O	
Neck	W	W/O	W & W/O											
Other:	W	W/O	W & W/O											

MAGNETIC RESONANCE IMAGING (MRI)

* See MRI contraindications on back of form

W/O *Only if Gadobutrol Allergy

Brain/Stem	W & W/O	W/O		Paranasal	W & W/O	W/O		Sacrum	W & W/O	W/O
MRI- Spectroscopy	W & W/O	W/O		Orbits	W & W/O	W/O		Chest	W & W/O	W/O
MRI-Functional	W & W/O	W/O		Abdomen	W & W/O	W/O		Brachial Plexus	W & W/O	W/O
MRV-Brain	W & W/O	W/O		Pelvis: Routine	W & W/O	W/O		Extremity Upper Joint Specify: R L	W & W/O	W/O
Temporal Bone (IAC)	W & W/O	W/O		Pelvis (circle): Prostate Female	W & W/O	W/O		Extremity Upper Non-Joint: Specify: R L	W & W/O	W/O
Neck - Soft Tissue	W & W/O	W/O		Pelvis MSK	W & W/O	W/O		Extremity Lower Joint: Specify R L	W & W/O	W/O
Pituitary	W & W/O	W/O		Pelvis/Rectal		W/O		Extremity Lower Non-Joint: Specify R L	W & W/O	W/O
Cervical Spine	W & W/O	W/O		MRCP * Must include Abdomen W & W/O		W/O		MRA: Body Part:	W & W/O	W/O
Thoracic Spine	W & W/O	W/O		Abdomen	W & W/O			Whole Body		W/O
Lumbar Spine	W & W/O	W/O		Renal	W & W/O	W/O		Liver	W & W/O	W/O
Brain/Stem (stereo) With Contrast Only										

PROVIDER SECTION

Clinical Indication, Sign, or Symptom for Medical Necessity: **PHYSICIAN/PROVIDER MUST COMPLETE**
Diagnosis:

Ordering Provider Signature _____ Date _____

IMAGING CONTRAST ORDER GUIDELINE

MR STUDIES ***

- **ALL** studies should be ordered → **with & without contrast**
 - » Exceptions:
 - ◇ Some musculoskeletal (MSK) studies without history of cancer → **without only**

******If the patient has any of the following, MRI cannot be performed:**

Cardiac defibrillator, pacemaker & tissue expander.

******All Abdomen/Pelvis exams require patient to be NPO for 2 hours prior to exam.**

CT STUDIES

- CT HEAD → **with & without contrast**
 - » Exception:
 - ◇ Benign sinus disease, CT Sinus → **without**
- CT Thorax → **with contrast**
 - » Exception:
 - ◇ Lung cancer screening * or interstitial lung disease → **without**
***Please complete the lung cancer screening eligibility form and fax to (313) 576-9827**
- CT ABDOMEN and/or PELVIS → **with contrast**
 - » Exceptions:
 - ◇ Baseline for Adrenal or renal mass → **without & without**
 - ◇ Urogram → **without & without**
 - ◇ Any Hemorrhage → **without & without**
 - ◇ Renal or ureteral stone → **without**
- CT Cryoablation zone → **with & without contrast**
 - » Exception:
 - ◇ If **GFR < 30** → **without only**

******If GFR 30 - 60, KCC Imaging Hydration protocol will be utilized for CT imaging.**

******All Abdomen/Pelvis exams require patient to be NPO for 2 hours prior to exam.**

******Questions about ordering a specialty radiology study, please call 576-9900 for radiologist consult.**