Today's Date: ____/____/____

ZOOM DIAGNOSTIC IMAGING

☐ **ARDMORE**
For Appointments: 580-319-5091
Fax Orders: 580-205-5012

☐ **DURANT**
For Appointments: 580-294-7030
Fax Orders: 580-924-5448

Patient Name: _____

DOB: ____/____/____ Employer: _____ SS#: _____

Insurance: _____ Group#: _____ Policy #: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Appointment Date: ____/____/____ Time: _____ Pregnant: ☐ Yes ☐ No

Diagnosis Code: _____ Reason for Exam: _____

Referring Physician (Print): _____ Office Phone: _____

Office Contact: _____ Office Fax: _____

☐ STAT REPORT _____ ☐ CALL STAT _____ ☐ Deliver CD ☐ Send CD with Patient

MRI - ☐ Ardmore ☐ Durant

☐ With Contrast
☐ With & Without Contrast
☐ Without Contrast
☐ RAD to Determine

NEURO/ENT/SPINE
☐ Brain
☐ Orbits
☐ Pituitary
☐ IAC
☐ Spine (select below)
☐ C ☐ T ☐ L
☐ TMJ
☐ Soft Tissue neck/parotid
Other _____

BODY & CHEST
☐ Abdomen
☐ Pelvis
☐ Prostate
☐ MRCP
☐ Breast MRI
☐ Clavicle/SC joint
☐ Scapula
☐ Sternum
Other _____

ORTHOPEDIC
☐ Extremity (select below)
☐ Left Arm ☐ Right Arm
☐ Left Leg ☐ Right Leg
Specify _____
☐ Wrist ☐ R ☐ L
☐ Knee ☐ R ☐ L

MRA
☐ Intracranial/ Circle of Willis
☐ Carotid
☐ Hip ☐ R ☐ L
☐ Shoulder ☐ R ☐ L

ULTRASOUND
☐ Ardmore ☐ Durant

☐ Carotids
☐ Extremity
☐ Pelvic
☐ Renal Doppler
☐ Abdominal
☐ Breast
☐ Renal Ultrasound
☐ AAA

☐ Venous ☐ Leg ☐ R ☐ L ☐ Bilat
☐ Arm ☐ R ☐ L ☐ Bilat
☐ Arterial ☐ Leg ☐ R ☐ L ☐ Bilat
☐ Arm ☐ R ☐ L ☐ Bilat
☐ Other _____

X-RAY
☐ Ardmore ☐ Durant

☐ Chest PA & LAT
☐ Abdomen, KUB
☐ Abdominal Series
☐ Pelvis
☐ C-Spine
☐ T-Spine
☐ L-Spine
☐ Other _____

☐ Shoulder ☐ R ☐ L
☐ Elbow ☐ R ☐ L
☐ Wrist ☐ R ☐ L
☐ Hand ☐ R ☐ L
☐ Hip ☐ R ☐ L
☐ Knee ☐ R ☐ L
☐ Ankle ☐ R ☐ L
☐ Foot ☐ R ☐ L

CT - ☐ Ardmore Only

☐ With Contrast
☐ With & Without Contrast
☐ Lung Screening
☐ Brain
☐ Spine (select below)
☐ C ☐ T ☐ L
☐ Facial bones
☐ Temporal lobes
☐ Complete Sinuses
☐ Soft Tissue Neck
☐ Extremity (select below)
☐ Left Arm ☐ Right Arm
☐ Left Leg ☐ Right Leg
☐ Without Contrast
☐ RAD to Determine
☐ Chest
☐ Abdomen Only
☐ Pelvis Only
☐ Abdomen & Pelvis Combined
☐ CTA _____
☐ Other _____
☐ Calcium Score

I certify that the item(s) prescribed is medically necessary for the treatment of this patient for the above condition and this information is documented in the patient medical records:

Referring Physician Signature: _____ Date: ____/____/____

(No Stamped Signatures)