



Minimally Invasive Surgical Solutions

Minimally Invasive Surgical Solutions (MISS)

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DIAGNOSTIC IMAGING PATIENT ORDER FORM



ORDER DETAILS

Patient Name _____ DOB (required) _____
Last First

Patient Address _____
Street Address City / State / Zip Code Phone Number Email Address

Secondary Contact _____
Contact Name Relationship to Patient Phone Number Email Address

Authorization required? ☐ Yes ☐ No Authorization # _____ Authorization Expiration Date ☐ Routine
PLEASE INCLUDE A LEGIBLE COPY OF THE INSURANCE CARD (BOTH SIDES), AND AUTHORIZATION IF REQUIRED. ☐ STAT: Reason _____

Referring MD _____ Phone _____ Fax _____

Form Completed by _____ Direct Phone number _____

MD Signature _____ CC MD _____

CC Patient: ☐

DIAGNOSIS (ICD-10 Required):

Letter	Number	Letter or Number

Symptoms / Clinical Concern _____



ULTRASOUND

Non-vascular

- | | |
|---|---|
| ☐ Liver | ☐ Pelvic (uterus, ovaries) |
| ☐ Kidney/Bladder | ☐ Pelvic (prostate) |
| ☐ Soft Tissue: Specify _____ | ☐ Scrotum / Testicle |
| ☐ Abdominal Complete (Liver, Gallbladder, CBD, Spleen) | ☐ Prostate Volume |
| ☐ Limited Abd: Specify _____ | ☐ Thyroid |



VASCULAR DUPLEX ULTRASOUND

Abdominal Vascular Evaluation

- | | |
|---|---|
| ☐ Aorta / Iliac / Common Femoral | ☐ Vascular Screening |
| ☐ Renal arteries with or w/o RENAL FLOW | |
| ☐ Portal vein PORTAL HYPERTENSION | |
| ☐ Mesenteric / Celiac trunk, SMA or GDA/MA | |
| ☐ Inferior Vena Cava / Iliac veins (Add DVT) | |

Venous Duplex Ultrasound

- | | |
|--|--|
| ☐ Venous for deep vein thrombosis, DVT | |
| ☐ R ☐ L ☐ Bilateral ☐ Arm ☐ Leg | |
| ☐ Varicose Veins ☐ Reflux | |
| ☐ Pre-op dialysis mapping ☐ R ☐ L | |

Vascular Duplex Ultrasound

- | |
|--|
| ☐ Carotid/vertebral arteries, bilateral |
| ☐ Arterial Duplex Extremities for leg pain |
| ☐ R ☐ L ☐ Bilateral |
| ☐ ABI ankle-brachial index (resting) |
| ☐ Arterial stents |
| ☐ Hemodialysis graft (fistula) |
| Specify _____ |



CT SCAN

Please specify:

- | | Contrast | W/O Contrast |
|---|--|--------------------------|
| ☐ Head | ☐ | ☐ |
| ☐ Neck | ☐ | ☐ |
| ☐ Chest—Routine | ☐ | ☐ |
| ☐ Chest—High Resolution | ☐ | ☐ |
| ☐ Chest—Low Dose | ☐ | ☐ |
| ☐ Chest—Super Dimensional 3D | ☐ | ☐ |
| ☐ Abdominal | ☐ | ☐ |
| ☐ Pelvis | ☐ | ☐ |
| ☐ C-Spine | ☐ | ☐ |
| ☐ Thoracic Spine | ☐ | ☐ |
| ☐ Lumbar Spine | ☐ | ☐ |
| ☐ Extremity | ☐ R ☐ L ☐ Bilateral | |
| | ☐ Arm ☐ Leg | |



CT ANGIOGRAM—CTA

Please specify:

- | | |
|--|--|
| ☐ Head | ☐ Renal Arteries |
| ☐ Neck | ☐ Aorta & Lower extremities Other |
| ☐ Chest | |
| ☐ Coronary CTA w/FFR & Plaque Analysis (if indicated) | |
| ☐ Calcium Scoring | |

Some Exams require Lab work prior to appointment.

Creatinine and BUN required for those patients receiving IV contrast for CTA who are:

- Diabetic
- History of renal insufficiency
- 70 years of age and older