



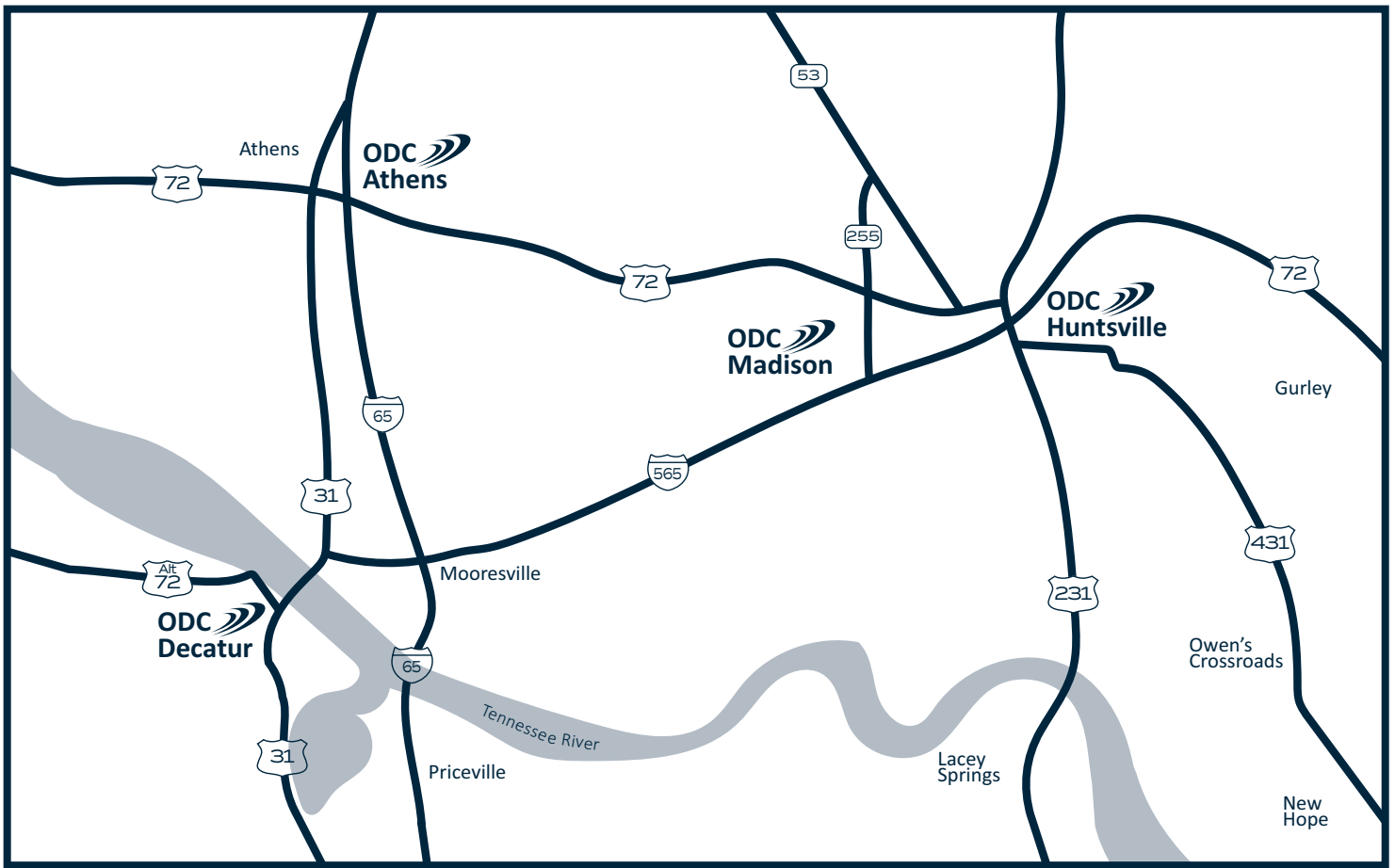
LOCATION: Huntsville Madison Athens Decatur





STAT CALL REPORT: _____

APPOINTMENT DETAILS: _____

CALL PATIENT TO SCHEDULE

PATIENT INFORMATION		PROVIDER INFORMATION	
Patient Name: _____		Provider Name: _____	
Date of Birth: _____		Signature: _____	
Phone: _____		Provider Phone: _____	
Insurance: _____		Provider Fax: _____	
Policy/Group #: _____ / _____		Authorization # _____	
ICD-10 / DIAGNOSIS / HISTORY / SPECIAL INSTRUCTIONS		MEDICARE ONLY	
_____		AUC/CDS G Code: _____ Modifier: _____	
_____		CPT Code Submitted: _____	
MRI	CT	Ultrasound	X-Ray
Radiologist to recommend contrast, unless otherwise specified here: _____			
<input type="checkbox"/> Brain <input type="checkbox"/> Attn: IAC <input type="checkbox"/> Attn: Pituitary	<input type="checkbox"/> Head <input type="checkbox"/> Orbits <input type="checkbox"/> Facial Bones	<input type="checkbox"/> Aorta <input type="checkbox"/> Breast <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilat <input type="checkbox"/> Automated Intelligence Breast (AIBUS)	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral <input type="checkbox"/> Weight Bearing <input type="checkbox"/> Flexion/Extension # of views: _____ <i>If none specified, standard protocol will be performed.</i>
<input type="checkbox"/> Orbits	<input type="checkbox"/> IACs/Temporal Bones	<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Skull
<input type="checkbox"/> TMJ	<input type="checkbox"/> Sinus	<input type="checkbox"/> Abdomen Complete	<input type="checkbox"/> Facial Bones
<input type="checkbox"/> Soft Tissue Neck	<input type="checkbox"/> Soft Tissue Neck	<input type="checkbox"/> Abdomen Limited (specify) _____	<input type="checkbox"/> Nasal Bones
<input type="checkbox"/> Brachial Plexus	<input type="checkbox"/> CTA Head	<input type="checkbox"/> Pelvis w/ TV if indicated	<input type="checkbox"/> Sinus Series
<input type="checkbox"/> MRA Brain	<input type="checkbox"/> CTA Neck	<input type="checkbox"/> Transvaginal	<input type="checkbox"/> Scapula
<input type="checkbox"/> MRV Brain	<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> Scrotum	<input type="checkbox"/> Chest (one view)
<input type="checkbox"/> MRA Carotid	<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/> Renal	<input type="checkbox"/> Chest (PA & Lat)
<input type="checkbox"/> MRA Renal	<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Sternum
<input type="checkbox"/> MRA Abdominal Aorta	<input type="checkbox"/> CTA Chest (PE Protocol)	<input type="checkbox"/> Carotid	<input type="checkbox"/> Ribs (Includes one view chest)
<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> CTA Aorta/Run-off	<input type="checkbox"/> ABI	<input type="checkbox"/> Cervical Spine
<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/> Calcium Cardiac Scoring	<input type="checkbox"/> Soft Tissue (specify) _____	<input type="checkbox"/> Thoracic Spine
<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/> Chest	<input type="checkbox"/> Pregnancy <input type="checkbox"/> 1st Trimester / Early OB <input type="checkbox"/> OB Complete >14 wks	<input type="checkbox"/> Lumbar Spine
<input type="checkbox"/> MRCP	<input type="checkbox"/> Lung Screening	<input type="checkbox"/> Arterial Doppler <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilat <input type="checkbox"/> Lower Ext. <input type="checkbox"/> Upper Ext.	<input type="checkbox"/> Scoliosis Series
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Abdomen/Pelvis	<input type="checkbox"/> Venous Doppler <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilat <input type="checkbox"/> Lower Ext. <input type="checkbox"/> Upper Ext.	<input type="checkbox"/> Abdominal Series
<input type="checkbox"/> Pelvis	<input type="checkbox"/> Stone Protocol (Abd/Pelvis)	<input type="checkbox"/> Ext. Non-Vascular <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilat <input type="checkbox"/> Lower Ext. <input type="checkbox"/> Upper Ext.	<input type="checkbox"/> Abdomen (KUB)
<input type="checkbox"/> Sacrum/Coccyx	<input type="checkbox"/> Abdomen <input type="checkbox"/> Adrenals <input type="checkbox"/> Liver <input type="checkbox"/> Pancreas <input type="checkbox"/> Kidney	<input type="checkbox"/> Renal Artery Doppler	<input type="checkbox"/> Pelvis
	<input type="checkbox"/> Pelvis	<input type="checkbox"/> AAA Screening	<input type="checkbox"/> Sacrum/Coccyx
	<input type="checkbox"/> Urogram		EXTREMITIES <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral <input type="checkbox"/> Weight Bearing
EXTREMITIES <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral	EXTREMITIES <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral		<input type="checkbox"/> Clavicle <input type="checkbox"/> Shoulder
<input type="checkbox"/> Shoulder <input type="checkbox"/> Humerus	<input type="checkbox"/> Shoulder <input type="checkbox"/> Humerus		<input type="checkbox"/> Humerus <input type="checkbox"/> Elbow
<input type="checkbox"/> Elbow <input type="checkbox"/> Forearm	<input type="checkbox"/> Elbow <input type="checkbox"/> Forearm		<input type="checkbox"/> Forearm <input type="checkbox"/> Wrist
<input type="checkbox"/> Wrist <input type="checkbox"/> Hand	<input type="checkbox"/> Wrist <input type="checkbox"/> Hand		<input type="checkbox"/> Hand <input type="checkbox"/> Finger
<input type="checkbox"/> Hip <input type="checkbox"/> Femur	<input type="checkbox"/> Hip <input type="checkbox"/> Femur		<input type="checkbox"/> Hip <input type="checkbox"/> Femur
<input type="checkbox"/> Knee <input type="checkbox"/> Tib/Fib	<input type="checkbox"/> Knee <input type="checkbox"/> Tib/Fib		<input type="checkbox"/> Knee <input type="checkbox"/> Tib/Fib
<input type="checkbox"/> Ankle <input type="checkbox"/> Forefoot	<input type="checkbox"/> Ankle <input type="checkbox"/> Foot		<input type="checkbox"/> Ankle <input type="checkbox"/> Foot
<input type="checkbox"/> Midfoot <input type="checkbox"/> Heel/Calcaneous			<input type="checkbox"/> Calcaneus <input type="checkbox"/> Toe
Other Procedures		Mammography / Women's Imaging	
<input type="checkbox"/> Arthrogram: _____ <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral		<input type="checkbox"/> Screening Mammogram w/ diagnostic and/or breast US if indicated	<input type="checkbox"/> Diagnostic Mammo <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilat w/ breast US if indicated
<input type="checkbox"/> DEXA _____		<input type="checkbox"/> AI Breast US (AIBUS)	<input type="checkbox"/> Breast US <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilat
<input type="checkbox"/> Other: _____		<input type="checkbox"/> DEXA _____	



	HUNTSVILLE	MADISON	ATHENS	DECATUR
	115 Saint Clair Ave SE Huntsville, AL 35801	398 Hughes Road Madison, AL 35758	22281 US Hwy 72 E Athens, AL 35613	1811 Beltline Rd SW Decatur, AL 35601
MRI	•	•	•	•
CT	•	•	•	•
Ultrasound	•	•	•	•
3D Mammography	•	•	•	
Bone Density	•	•	•	
X-ray	•	•	•	•
Scan for step by step directions via Google Maps				

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