InnerVision
A UNITY HEALTHCARE PARTNER

Scheduling: 765.447.7447, Fax: 765.447.1767
Outside Lafayette: *toll free* 866.ALL.SCAN

Order Form

□ **InnerVision Main**
1411 South Creasy Lane, Suite 130
Lafayette, IN 47905

□ **InnerVision Nuclear Medicine / PET / DEXA**
3801 Amelia Avenue, Suite A
Lafayette, IN 47905

Your Appointment: Month:_____ Date:_____ Time:_____

□ **Call Patient to Schedule Imaging**
□ **Alert Office of Scheduled Date**

Patient Name:_____ DOB:_____Phone:_____
Patient's Weight_____ lbs. Prior relevant studies? □ Yes □ No If yes, please list facility:_____
□ Serum Creatinine for Imaging Purpose Per Protocol

Indication for Study / Diagnosis / ICD 10 (required)	**Insurance Authorization/Clinical Decision Support**

Special Instructions:_____
Physician Signature:_____ Date:_____
Other Physicians to receive the Report:_____

☐ **Left** ☐ **Right** ☐ Without Contrast ☐ With I.V. Contrast ☐ With I.V. & Without I.V. Contrast ☐ Oral Contrast

Select	MRI	Select	CT	Select	ULTRASOUND
	Brain		**CT SPINE**		Abdomen Complete
	Brain w/ IAC		Cervical		Abdomen Limited
	Brain w/ Orbits		Thoracic		Aorta
	IAC		Lumbar		Aorta Screening
	Orbits		**CT HEAD**		Appendix
	Neck (Soft Tissue)		Brain		Carotid Artery Bilateral
	Cervical Spine		Facial Bones		Extremity for palpable abnormality* Document in special instructions the area to be scanned
	Thoracic Spine		IAC (Mastoids)		
	Lumbar Spine		Orbits		Kidneys Only
	Chest (Mediastinum)		Sinus		Kidney / Bladder
	Abdomen		**CT BODY**		Paracentesis _____Tx _____Dx
	Prostate		Neck		Pelvic Ultrasound w/ Transvaginal if needed
	MRI UPPER EXTREMITY		Chest		Renal Artery Doppler
	Hand		Abdomen		Soft Tissue Mass
	Wrist		Pelvis		Testicular
	Elbow		**CT MYELOGRAM (circle one)**		Thyroid
	Humerous		Cervical / Thoracic / Lumbar		Thyroid Biopsy
	Shoulder		**CT UROGRAM** (CT AP W/WO)		Ultrasound Guided Biopsy **Specify Site:**
	Soft Tissue Mass _____ Specify ___		**CTA (circle one)**		
	MRI LOWER EXTREMITY		Brain / Carotids / Chest / Abdomen / Pelvis		
	Foot		**CT LUNG SCREENING WITHOUT**		
	Ankle		**CT EXTREMITY** Specify:		
	Tibula / Fibula				
	Knee		**CT STEROID INJECTION SITE** Specify:		**VENOUS EXTREMITY** (circle one) left / right / bilateral
	Femur				
	Hips				Upper
	Pelvis				Lower
	MR ARTHROGRAM Specify:		**CT Enterography**	**COMMENTS:**	
	MR ANGIOGRAPHY Specify:		**MR Other** Specify:		

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Physician Signature:_____ Date:_____
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☐ **Left** ☐ **Right** ☐ **Bilateral**

Select	XRAY
	KUB
	Acute Abdomen
	Ankle
	Chest
	Cervical Spine
	Elbow
	Femur
	Fingers
	Foot
	Forearm
	Hand
	Heel / Calcaneous
	Hip
	Humerus
	Knee
	Lumbar Spine
	Metastatic Survey
	Neck (Soft Tissue)
	Orbits
	Sinuses
	Pelvis
	Ribs
	Sacrum & Coccyx
	Shoulder
	Thoracic Spine
	Thoracolumbar
	Tibia & Fibula
	Toes
	Wrist

Select	NUCLEAR MEDICINE
	Bone Imaging - SPECT
	Bone Imaging - LTD
	Bone Imaging - 3 Phase
	Bone Imaging - Whole Body
	MUGA
	Hepatobiliary (HIDA)
	Kidney Flow / Fxn
	w/ Lasix
	Thyroid Uptake and Scan
	Prostascint
	Cisternogram
	Parathyroid
	Lung V/Q
	Bone Indium - In III WBC Study
	Gastric
	Octreoscan
	Xofigo
	PET ___Initial ___ Restaging
	PET / CT Brain
	PET / CT WB
	PET / CT Skull Base to Thigh

Select	FLUOROSCOPY
	Esophagram (Barium Swallow)
	UGI
	UGI/SBFT
	Small Bowel
	Colon Double Contrast (for failed colonoscopy only)
	Hysterosalpingogram
	FL Lumbar Puncture
	Myelogram (circle one) cervical / thoracic / lumbar
	Steroid Injection Joint Specify:
	IR
	Kyphoplasty Level(s)_____
	Port Placement
	Port Removal
	BONE DENSITY
	(DEXA) Bone Density with (VFA) Vertebral Fracture Assessment
	(DEXA) Bone Density **W/O** (VFA) Vertebral Fracture Assessment
	Body Composition