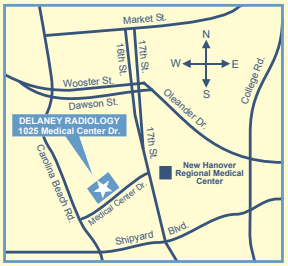
Delaney Radiology

DELANEY RADIOLOGY
BONE DENSITY REFERRAL

1025 Medical Center Drive • Wilmington, NC 28401
Phone: (910) 762-3882 • Fax: (910) 762-6739
www.delaneyrad.com

FOR ALL SCHEDULING CALL 762-3882 or FAX 762-6739



DELANEY NO. _____ Today's Date _____

PATIENT'S NAME _____ PHONE _____ D.O.B. _____

DATE OF APPOINTMENT _____ TIME _____

PRIMARY INSURANCE _____ GROUP # _____ AUTH. # _____

SECONDARY INSURANCE _____ GROUP # _____ AUTH. # _____

PHYSICIAN SIGNATURE X _____ **PRINTED NAME** _____

BONE DENSITOMETRY (DEXA) ☐ (Lumbar Spine and Hip Scans) **AND/OR** ☐ (Forearm)

ICD-10 DIAGNOSIS AND/OR CLINICAL SIGNS OR SYMPTOMS _____

PLEASE CHECK ALL THAT APPLY:

- ☐ Postmenopausal age related
- ☐ Osteopenia
- ☐ Osteoporosis (Age related without fracture)
- ☐ Hyperparathyroidism
- ☐ Postmenopausal surgical
- ☐ Ovarian Failure
- ☐ Patient has been determined estrogen deficient and at risk for osteoporosis
- ☐ Patient is currently getting (or expected to get) glucocorticoid therapy > 3 months
- ☐ Patient is being monitored for FDA approved osteoporosis drug therapy
- ☐ Other menopausal & perimenopausal disorder
- ☐ Screening for Osteoporosis (Not an approved Medicare diagnosis)

PRIOR SCREENING

Where: _____

When: _____

PLEASE BRING THIS REFERRAL TO DELANEY RADIOLOGY

REV. 5-21

Please bring your insurance information for filing. For your comfort, please wear a two piece, elastic waist outfit.

BREAST IMAGING REFERRAL

Delaney Radiology
Women's Imaging Services

1025 Medical Center Drive • Wilmington, NC 28401
Phone: (910) 762-3882 • Fax: (910) 762-6739
www.delaneyrad.com

DESIGNATED COMPREHENSIVE BREAST IMAGING CENTER — American College of Radiology

TODAY'S DATE _____

PATIENT'S NAME _____ DOB _____ DELANEY NO. _____

DATE OF APPOINTMENT _____ TIME _____ PT. PHONE _____

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____

PROVIDER SIGNATURE *X* _____ **PRINTED NAME** _____

SCREENING EXAMS

❑ **SCREENING MAMMOGRAM** (Routine exam only - No current problems)
- ❑ Additional imaging if recommended by radiologist
  - ❑ Proceed to biopsy if needed based on further imaging workup

❑ **SCREENING BREAST ULTRASOUND** (Routine screening, dense breasts or family history of breast cancer)
- ❑ Ultrasound guided biopsy and/or aspiration if clinically indicated by the radiologist

DIAGNOSTIC EXAMS

❑ **COMPREHENSIVE DIAGNOSTIC BREAST IMAGING** (Includes mammogram, ultrasound and/or biopsy if recommended by radiologist)
- ❑ Bilateral ❑ Left ❑ Right

❑ **LIMITED DIAGNOSTIC BREAST IMAGING**

❑ Mammogram with U/S as needed	❑ Bilateral	❑ Left	❑ Right
❑ Mammogram *Only*	❑ Bilateral	❑ Left	❑ Right
❑ Ultrasound *Only* **(LIMITED / COMPLETE)** *circle one*	❑ Bilateral	❑ Left	❑ Right
❑ Stereotactic or U/S Guided Core Biopsy, FNA, Cyst Aspiration *Only*	❑ Bilateral	❑ Left	❑ Right

❑ **MRI BREAST** *A serum creatinine level within the last 30 days is required for patients with any of the following:*

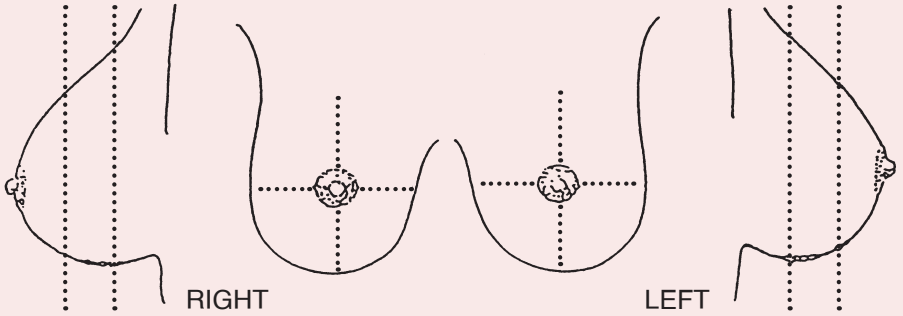
❑ Age >60	❑ Renal Dialysis	❑ Sickle Cell Anemia
❑ Diabetes	❑ Kidney Disease / Solitary Kidney	❑ Multiple Myeloma
❑ Hypertension (or meds for HTN)	❑ Chemotherapy within last 30 days	❑ Pheochromocytoma

- ❑ History of severe liver disease, transplant, pending transplant **(I-STAT same day as MRI)**
- ❑ **Delaney to provide creatinine testing on day of exam**

REASON FOR DIAGNOSTIC EXAM **By selecting one of the options below, this automatically converts a screening exam to a diagnostic exam.**
(Please use diagram below when appropriate)

❑ Mass or Lump	❑ Nipple Discharge: bloody or clear
❑ Calcifications	❑ Localized Pain
❑ Fibrocystic Changes	❑ Personal History of Breast Cancer *(within last 5 years)*
❑ Abnormal Prior Mammogram *(radiologist recommended follow-up)*	❑ Other _____

❑ Additional Clinical Information _____



REV. 1-25

Please bring this referral and your insurance information to your appointment. Please do not use deodorant or powder on breasts or under arm area on the day of your exam.

MRI REFERRAL FORM
FOR MRI SCHEDULING

Delaney Radiology

Phone: (910) 762-3882 • Fax: (910) 762-6739
www.delaneyrad.com

☐ 1025 Medical Center Drive
Wilmington, NC 28401

☐ 2800 Ashton Drive Ste. 102
Wilmington, NC 28412

DELANEY NO. _____ TODAY'S DATE _____

PATIENT'S NAME _____ D.O.B. _____

PATIENT'S PHONE _____ SECONDARY PHONE _____

PRIMARY INSURANCE _____ GROUP # _____ AUTH. # _____

SECONDARY INSURANCE _____ GROUP # _____ AUTH. # _____

MRI APPOINTMENT DATE _____ TIME _____

F/UP APPOINTMENT WITH REFERRING: DATE _____ **TIME** _____

DIAGNOSIS AND/OR CLINICAL SIGNS OR SYMPTOMS **(DO NOT USE R/O)** _____

_____

PHYSICIAN'S SIGNATURE *X* _____ **PRINTED NAME** _____

MEDICARE ONLY

WHAT CLINICAL DECISION SUPPORT MECHANISM WAS USED (G-CODE)? _____

WHICH AUC CODE WAS GIVEN (HCPCS MODIFIER)? _____

EXAM(S) REQUESTED

☐ **Without Contrast** ☐ **With / Without Contrast** ☐ **Per Radiologist**

☐ MRI Brain	☐ MRI Breast	☐ MRI Thoracic Spine	☐ MRI Hand Left Right
☐ MRI Pituitary	☐ MRI Abdomen	☐ MRI Lumbar Spine	☐ MRI Hip Left Right
☐ MRI IACs	☐ MRCP	☐ MRI Sacrum	☐ MRI Knee Left Right
☐ MRA Brain	☐ MRI Pelvis	☐ MRI Bony Pelvis	☐ MRI Ankle Left Right
☐ MRV Brain	☐ MRI Pelvis - GYN	☐ MRI Shoulder Left Right	(Ankle/Hindfoot)
☐ MRI Neck Soft Tissue	☐ MRI Prostate	☐ MRI Elbow Left Right	☐ MRI Foot Left Right
☐ MRA Neck	☐ MRI Cervical Spine	☐ MRI Wrist Left Right	(Forefoot/Midfoot)

Other _____

Radiologist's Protocol _____

_____

CREATININE TESTING

For MR exams requiring IV contrast, a serum creatinine level within the last 30 days is required for patients with any of the following:

☐ Age >60	☐ Renal Dialysis	☐ Sickle Cell Anemia
☐ Diabetes	☐ Kidney Disease / Solitary Kidney	☐ Multiple Myeloma
☐ Hypertension (or meds for HTN)	☐ Chemotherapy (within last 30 days)	☐ Pheochromocytoma
☐ History of severe liver disease, transplant, pending transplant **(Istat same day as MR)**		☐ None _____ (initials)

☐ **DELANEY TO PROVIDE CREATININE TESTING ON DAY OF EXAM**

_____ **CREATININE** _____ **LOCATION & DATE DRAWN (must be within last 30 days)**

FOR TECHNOLOGIST USE ONLY _____ **I-STAT CREATININE**

PREVIOUS X-RAYS, CT, OR MRI: ☐ Yes ☐ No ☐ Patient to bring ☐ Will send by courier

Where / When? _____

Send Films / CDs to: ☐ Referring MD Office ☐ Other _____

GFR:

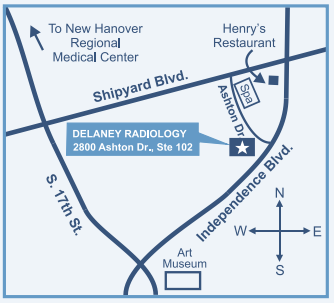
GFR acceptable range >51
GFR 30-50 - half dose
GFR < 30 - contact Radiologist

REV. 6-20

IMPORTANT: If you cannot meet your appointment, please notify our office 24 hours in advance.

Delaney Radiology

RADIOLOGY REFERRAL FORM



FOR ALL SCHEDULING

Phone: (910) 762-3882 or Fax: (910) 762-6739

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☐ **1025 Medical Center Drive**
Wilmington, NC 28401

☐ **2800 Ashton Drive Ste. 102**
Wilmington, NC 28412

DELANEY NO. _____ Today's Date _____

PATIENT'S NAME _____ D.O.B. _____ PHONE _____

DATE OF APPOINTMENT _____ TIME _____

PRIMARY INSURANCE _____ GROUP # _____ AUTH. # _____

SECONDARY INSURANCE _____ GROUP # _____ AUTH. # _____

PHYSICIAN'S SIGNATURE *X* _____ **PRINTED NAME** _____

EXAM REQUESTED _____

DIAGNOSIS AND/OR CLINICAL SIGNS OR SYMPTOMS **(DO NOT USE R/O)** _____

_____

FOR CT EXAMS, LIST ALL KNOWN ALLERGIES _____

KNOWN HISTORY OF IV CONTRAST ALLERGY ☐ YES ☐ NO

MEDICARE ONLY

WHAT CLINICAL DECISION SUPPORT MECHANISM WAS USED (G-CODE)? _____

WHICH AUC CODE WAS GIVEN (HCPCS MODIFIER)? _____

CREATININE TESTING

For exams requiring IV contrast, a serum creatinine level within the last 30 days is required for patients with any of the following:

☐ Age >60
☐ Diabetes
☐ Hypertension (or meds for HTN)
☐ Renal Dialysis
☐ Kidney Disease / Solitary Kidney
☐ Chemotherapy (within last 30 days)
☐ Sickle Cell Anemia
☐ Multiple Myeloma
☐ Pheochromocytoma
☐ History of severe liver disease, transplant, pending transplant **(Istat same day as MR or CT)**
☐ None _____ (initials)
☐ **DELANEY TO PROVIDE CREATININE TESTING ON DAY OF EXAM**

_____ **CREATININE** _____ **LOCATION & DATE DRAWN (must be within last 30 days)**

FOR TECHNOLOGIST USE ONLY _____ **I-STAT CREATININE**

Technologist Use Only

Manuf: _____ Lot #: _____ Amount: _____ Exp. Date: _____

Injection Site: _____ Injected by: _____

Post Observation: ☐ Red ☐ Pain ☐ Swelling ☐ Extravasation ☐ None

Send CD: ☐ with patient ☐ other _____

☐ Call report today Phone number _____

☐ Hold patient and call stat report _____

Prior films/testing: where/when? _____

GFR:

GFR acceptable range >51
GFR 30-50 - half dose
GFR < 30 - contact Radiologist

Please bring this referral sheet to Delaney Radiology.

REV. 11-20

Please bring your insurance information for filing.

ULTRASOUND REFERRAL

1025 Medical Center Drive • Wilmington, NC 28401
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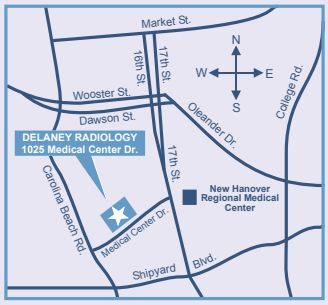
Delaney Radiology



DELANEY NO. _____ Today's Date _____

PATIENT'S NAME _____ D.O.B. _____ PHONE _____

DATE OF APPOINTMENT _____ TIME _____

PRIMARY INSURANCE _____ GROUP # _____ AUTH. # _____

SECONDARY INSURANCE _____ GROUP # _____ AUTH. # _____

PHYSICIAN'S SIGNATURE X _____ **PRINTED NAME** _____

DIAGNOSIS AND/OR CLINICAL SIGNS OR SYMPTOMS **(DO NOT USE R/O)** _____

_____ ICD-10 _____

EXAM REQUESTED

	Soft Tissue Head/Neck	76536		Scrotal With Duplex (76870 & 93976)	76870 Duplex
	Limited Breast (focal area of concern) Right	76642R		Carotid Duplex	93880
	Limited Breast (focal area of concern) Left	76642L		Bilateral Venous Upper Extremities	93970 Upper
	Complete Breast (entire breast) Right	76641R		Venous Upper Extremity Left	93971 LU
	Complete Breast (entire breast) Left	76641L		Venous Upper Extremity Right	93971 RU
	Abdomen Limited	76705		AAA Screening	76706
	Abdomen Complete	76700		Retroperitoneal Limited, Aorta	76775
	Hepatic Duplex	93975H		Duplex of Aorta, IVC or Iliac Arteries	93978
	Retroperitoneal Complete, Renal	76770		Bilateral Venous Lower Extremities	93970Lower
	Renal Transplant	76776		Venous Lower Extremity Left	93971LL
	Renal Artery Duplex	93975		Venous Lower Extremity Right	93971RL
	Pelvis Limited	76857		Duplex Bilateral Arterial Lower Extremities	93925
	Pelvis Complete (only)	76856		Duplex Bilateral Arterial Lower Extremities w/ABI	93925ABI
	Pelvis Complete and Transvaginal (76856 & 76830)	76856 PUS		(93925 & 93922)	
	Transvaginal (only)	76856		Ankle Brachial Indices	93922

OTHER EXAM NOT LISTED: _____

_____

Send CD: ☐ With Patient ☐ Other Instructions: _____

☐ Call Report Today - Phone Number: _____

☐ Hold Patient and Call STAT Report - Phone Number: _____

Prior Films / Testing: Where / When? _____

Please bring this referral sheet to Delaney Radiologists.

REV. 10-20

Please bring your insurance information for filing.

Delaney Radiology

UROLOGY REFERRAL

1025 Medical Center Drive
Wilmington, NC 28401
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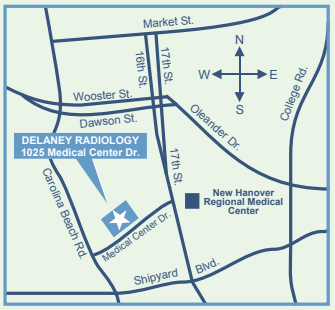
www.delaneyrad.com



DELANEY NO. _____ Today's Date _____

PATIENT'S NAME _____ PHONE _____ D.O.B. _____

DATE OF APPOINTMENT _____ TIME _____

PRIMARY INSURANCE _____ GROUP # _____ AUTH. # _____

SECONDARY INSURANCE _____ GROUP # _____ AUTH. # _____

PHYSICIAN SIGNATURE *X* _____ **PRINTED NAME** _____

DIAGNOSIS AND/OR CLINICAL SIGNS OR SYMPTOMS _____

(DO NOT USE R/O)

KNOWN HISTORY OF IV CONTRAST ALLERGY ❑ YES ❑ NO

MEDICARE ONLY

WHAT CLINICAL DECISION SUPPORT MECHANISM WAS USED (G-CODE)? _____

WHICH AUC CODE WAS GIVEN (HCPCS MODIFIER)? _____

CREATININE TESTING

For exams requiring IV contrast, a serum creatinine level within the last 30 days is required for patients with any of the following:

❑ Diabetes ❑ Renal Dialysis ❑ Sickle Cell Anemia
❑ Hypertension (or meds for HTN) ❑ Kidney Disease / Solitary Kidney ❑ Multiple Myeloma
❑ Chemotherapy (within last 30 days) ❑ Pheochromocytoma ❑ None _____ (initials)

_____ CREATININE _____ LOCATION & DATE DRAWN (must be within last 30 days)

❑ **DELANEY TO PROVIDE CREATININE TESTING ON DAY OF EXAM** _____ I-STAT CREATININE

		CPT CODES
❑	**CT RENAL PROTOCOL** CT ABDOMEN AND PELVIS WITHOUT CONTRAST - (RENAL STONE IMAGING) NO PREPARATION	**74176**
❑	**CT HEMATURIA PROTOCOL** CT ABDOMEN AND PELVIS, WITH AND WITHOUT CONTRAST INCLUDES DIGITAL RECONSTRUCTION OF URETERS NPO 4 HOURS PRIOR TO EXAM AND LABS IF NEEDED	**74178**
❑	**CT RENAL MASS PROTOCOL** CT ABDOMEN WITH AND WITHOUT CONTRAST - (NO PELVIC IMAGING) NPO 4 HOURS PRIOR TO EXAM AND LABS IF NEEDED	**74170**
❑	**CT RENAL ANGIO PROTOCOL** CT ANGIO OF THE ABDOMEN WITH AND WITHOUT CONTRAST NO PELVIC IMAGING - INCLUDES DIGITAL RECONSTRUCTION OF VESSELS NPO 4 HOURS PRIOR TO EXAM AND LABS IF NEEDED	**74175**
❑	**ULTRASOUND KIDNEYS AND BLADDER** FULL BLADDER UPON ARRIVAL IS REQUIRED	**76770**
❑	**ULTRASOUND RENAL ARTERIES** (NOTHING AFTER MIDNIGHT AND THE MORNING OF THE EXAM)	**93975**
❑	**ULTRASOUND RENAL TRANSPLANT** (NO PREPARATION)	**76776**
❑	**ULTRASOUND SCROTUM/TESTICULAR WITH DUPLEX** (NO PREPARATION)	**76870 & 93976**
❑	**X-RAY - KUB** (NO PREPARATION)	**74000**
❑	**MRI PROSTATE** (MULTIPARAMETRIC) (NO PREPARATION)	**72197 PROSTATE**
❑	OTHER: _____	

SEND CD: ❑ WITH PATIENT ❑ OTHER _____

❑ CALL REPORT TODAY - PHONE # _____

❑ HOLD PATIENT AND CALL REPORT ❑ PRIOR FILMS/TESTING: WHERE/WHEN? _____

Please bring this referral sheet to Delaney Radiology.

Please bring your insurance information for filing.

REV. 10-20

Delaney Radiology

IMAGE-GUIDED OUTPATIENT PARACENTESIS REFERRAL FORM

TO SCHEDULE: (910) 762-3882 - TO FAX ORDER: (910) 762-6739

1025 Medical Center Drive Wilmington, NC 28401 www.delaneyrad.com

DELANEY NO. _____ **Today's Date _____**

PATIENT'S NAME _____ D.O.B. _____ PHONE_____

PRIMARY INSURANCE _____ GROUP# _____ AUTH#_____

SECONDARY INSURANCE _____ GROUP# _____ AUTH#_____

DIAGNOSIS AND/OR CLINICAL SYMPTOMS _____ ICD-10 _____

COMMENTS/SPECIAL INSTRUCTIONS _____

MD NAME _____ **MD PHONE** _____

PHYSICIAN'S SIGNATURE _____

STANDING ORDER: ☐ **YES** ☐ **NO** **FREQUENCY** _____

IMAGE-GUIDED PARACENTESIS: ☐ **DIAGNOSTIC** ☐ **THERAPEUTIC**

SEND FLUID FOR CELL COUNT WITH DIFFERENTIAL AND CULTURE & SENSITIVITY. ☐ **YES** ☐ **NO**

☐ **TOTAL PROTEIN** ☐ **ALBUMIN** ☐ **CYTOLOGY**

GIVE SALT POOR ALBUMIN 25g IV PER 3 LITER OF FLUID REMOVED. ☐ **YES** ☐ **NO**

LIMIT: _____

R/B/A DISCUSSED WITH PATIENT REGARDING BLOOD PRODUCT INFUSION. ☐ **YES** ☐ **NO**

PT/INR (IF NEEDED) _____