ONCOLOGY SPECIALISTS OF CHARLOTTE

A Partner of OneOncology

CT SCAN ORDER FORM

PATIENT INFORMATION **TODAY'S DATE** _____

Patient Name:	DOB:
Patient Address:	Patient Phone:
Indication for CT/ Diagnosis:	ICD-10:
Is this STAT? ☐ YES ☐ NO (If YES, Please provide CMP within 48 hours)	
Is the patient Diabetic? ☐ YES ☐ NO (If YES, please provide blood labs within 6 weeks)	
Special Appointment Request:	

INSURANCE

NPI#: 14674406736 **TIN#:** 56-2179043 **Authorization#:**_____

Primary:	ID#:
Secondary:	ID#:

ORDER SPECIFICS - Types of CT Scan

☐ Chest	☐ Abdominal/Pelvis	☐ Abdominal	☐ **BOTH** IV & Oral Contrast	☐ **WITH** IV Contrast Only
☐ Head	☐ Neck-soft Tissue	☐ CT-PE Protocol	☐ **WITH** Oral Contrast	☐ **NO** IV or Oral Contrast
☐ **Patients Getting Contrast**, Most Recent Creatinine Levels:				

REFERRING PROVIDER INFORMATION

Office Contact:	Phone #:
Practice:	Imaging Report to Fax #:
Referring Provider:	Signature:
A radiologist report of the scan findings will be faxed to the number you indicated on this form	
Will you need the images? ☐ YES ☐ NO	
If ☐ YES, what is your Nuance PowerShare registered name:	

***** Please fax all pertinent progress notes, radiology reports, demographics, and insurance cards to Fax #: 704.377.0353 *****

CHARLOTTE
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