Baptist Health Imaging Services Scheduling - Western Region

BAPTIST HEALTH OUTPATIENT IMAGING CENTERS

☐ **Baptist Health Imaging Center-Fort Smith** Phone: 479-709-7404 Fax: 501-307-3069
(CT, Low Dose CT Lung Screening, Ultrasound, X-ray)

☐ **Baptist Health Breast Center-Fort Smith** Phone: 479-709-7404 Fax: 501-274-5587
(Automated Breast Ultrasound (ABUS), Bone Density (DEXZ), Breast Biopsies, 3D Mammography, Ultrasound)

BAPTIST HEALTH HOSPITAL-BASED CENTERS

☐ **Baptist Health-Fort Smith** Phone: 479-441-4181 Fax: 501-307-3069
(CT, Calcium CT Scoring, Cardiac CTA, DaTscan, MRI, Nuclear Medicine, PET/CT, Ultrasound, X-ray)

☐ **Baptist Health-Van Buren** Phone: 479-471-4370 Fax: 501-307-3069
(CT, Ultrasound, X-ray)

Form Completed By: _____ **Number:** _____

PHYSICIAN ORDERS

Appointment Date: _____ **Appointment Time:** _____

Pre-Certification #: _____ Last four of Patient Social Security #: _____

Patient Name: _____ DOB: _____

Test / Procedure: ☐ MRI ☐ CT ☐ CTA ☐ Bone Density ☐ PET/CT ☐ Breast Biopsy
☐ Ultrasound *(with Doppler if indicated)* ☐ X-ray ☐ Nuclear Medicine ☐ Mammogram

Test Description: _____

Contrast Study? ☐ With ☐ Without ☐ With/Without

Contrast allergy? ☐ YES ☐ NO

Is patient diabetic? ☐ YES ☐ NO

If patient is known diabetic, creatinine / date: _____

Diagnosis Code/Reason for Scan: _____

ICD-10 Code/Symptoms: _____

CPT Code: _____

DSN #: _____ **Score:** _____

Special Instructions: _____

Please check if patient is claustrophobic. ☐

Please check if patient has a history of cancer. ☐

Type of CA: _____

Provider Name (typed/required)**:** _____ ☐ Call Report (Wet Reading) to referring

Provider Signature (required)**:** _____ physician cell phone # _____

☐ CD with patient

Baptist Health
IMAGING CENTERS