Baptist Health Imaging Services Scheduling

BAPTIST HEALTH OUTPATIENT IMAGING CENTERS

☐ **Baptist Health Imaging Center-Kanis,** *A Department of BHMC-LR* — Phone: 501-202-4020 Fax: 501-850-0493
(CT, Large Bore MRI-500lb weight limit, Ultrasound, X-ray)

☐ **Baptist Health Imaging Center-North Little Rock,** *A Department of BHMC-NLR* — Phone: 501-202-6999 Fax: 501-850-0489
(CT, Large Bore MRI-500lb weight limit, Low Dose CT Lung Screening, Ultrasound)

☐ **Baptist Health Imaging Center-Saline County** — Phone: 501-776-2006 Fax: 501-850-0486
(CT, Large Bore MRI-550lb weight limit, Ultrasound, 3D Mammography, Bone Density, Low Dose CT Lung Screening)

BAPTIST HEALTH HOSPITAL-BASED CENTERS

☐ **Baptist Health Medical Center-Little Rock** — Phone: 501-202-1900 Fax: 501-850-0488
(CT, Nuclear Medicine, Ultrasound, X-ray, DaTscan)

☐ **Baptist Health MRI-Little Rock** — Phone: 501-202-1237 Fax: 501-850-0488
(Large Bore MRI-500lb weight limit, 3T MRI, Breast MRI, Cardiac MRI)

☐ **Baptist Health PET/CT Imaging Center-Little Rock** — Phone: 501-202-1900 Fax: 501-850-0488
(PET/CT)

☐ **Baptist Health Breast Center-Little Rock** — Phone: 501-202-1922 Fax: 501-274-5587
(3D Mammography, ABUS, Bone Density, Breast Biopsies, Ultrasound)

☐ **Baptist Health Medical Center-North Little Rock** — Phone: 501-202-3400 Fax: 501-850-0489
(CT, Large Bore MRI-500lb weight limit, Nuclear Medicine, Ultrasound, X-ray, PET/CT, Cardiac CTA, Cardiac MRI, DaTscan)

☐ **Baptist Health Breast Center-North Little Rock** — Phone: 501-202-1922 Fax: 501-274-5587
(3D Mammography, ABUS, Bone Density, Breast Biopsies, Ultrasound)

☐ **Baptist Health Medical Center-Conway** — Phone: 501-585-2200 Fax: 501-850-0485
(CT, Large Bore MRI-500lb weight limit, Nuclear Medicine, PET/CT, Ultrasound, X-ray, 3D Mammography, Bone Density, DaTscan, Low Dose CT Lung Screening)

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

PHYSICIAN ORDERS

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

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

Patient Name: _____ DOB: _____

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

Test Description: _____

_____

Diagnosis Code/Reason for Scan: _____

ICD-10 Code/Symptoms: _____

_____

CPT Code: _____

DSN #: _____ **Score:** _____

Special Instructions: _____

Contrast Study? ☐ With ☐ Without ☐ With/Without

Contrast allergy? ☐ YES ☐ NO

Is patient diabetic? ☐ YES ☐ NO

If patient is known diabetic, creatinine / date:

_____

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 # _____

Baptist Health
IMAGING CENTERS

☐ CD with patient