Baptist Health Imaging Services Scheduling - Regionals

BAPTIST HEALTH HOSPITAL-BASED CENTERS

☐ **Baptist Health Medical Center-Arkadelphia** *(Bone Density, CT, Large Bore MRI-500lb weight limit, Ultrasound, X-ray, 3D Mammography, ECHO)*	Phone: 870-245-1111	Fax: 501-850-0484
☐ **Baptist Health Medical Center-Drew County** *(Bone Density, CT, Low Dose CT Lung Screening, MRI, Nuclear Medicine, Ultrasound, X-ray, 3D Mammography, ECHO)*	Phone: 870-460-4898	Fax: 870-345-2510
☐ **Baptist Health Medical Center-Heber Springs** *(Bone Density, Calcium CT Scoring, CT, Large Bore MRI-550lb weight limit, Low Dose CT Screening, Ultrasound, X-ray, 3D Mammography, ECHO, PET/CT)*	Phone: 501-887-3272	Fax: 501-850-0487
☐ **Baptist Health Medical Center-Hot Spring County** *(Bone Density, CT, Large Bore MRI-550lb weight limit, Ultrasound, X-ray, 3D Mammography, ECHO)*	Phone: 501-332-7050	Fax: 501-850-0492
☐ **Baptist Health Medical Center-Stuttgart** *(Bone Density, CT, Calcium CT Scoring, MRI-350lb weight limit, Low Dose CT Lung Screening, Ultrasound, X-ray, 3D Mammography, ECHO)*	Phone: 870-674-6381	Fax: 501-850-0491

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 ☐ ECHO ☐ 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)**:** _____

Provider Signature (required)**:** _____

☐ Call Report (Wet Reading) to referring physician cell phone # _____

☐ CD with patient

Baptist Health
IMAGING CENTERS