

**OUTSIDE PHYSICIAN ORDER FOR  
RADIOLOGY/ NUCLEAR MEDICINE  
Consultation/ Request for Procedure**

University of Iowa Hospitals and Clinics  
Department of Radiology

Radiology Scheduling 319-356-3444 Fax: 319-353-8780  
PET Imaging 319-356-4100 Fax: 319-353-6512  
Nuclear Medicine 319-356-1911 Fax: 319-384-6389

UIHC MRN \_\_\_\_\_

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_

**Is the patient insured? Yes No**

**If yes, please send insurance information with this requisition**

Procedure (s) \_\_\_\_\_

Diagnosis relevant to request for procedure OR signs/symptoms and pertinent clinical findings

Requesting Physician (please print) \_\_\_\_\_ NPI Number \_\_\_\_\_

Requesting Physicians Signature \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**Additional Information**

|                                                         |                         |                                                                   |                                         |
|---------------------------------------------------------|-------------------------|-------------------------------------------------------------------|-----------------------------------------|
| <b>Patient Transport</b><br>Walk Chair<br>Cart Isolette | <b>Pregnant</b> Yes No  | <b>Allergy to contrast agent/sedation drug or latex:</b><br>_____ | <b>ICD-9-CM Diagnosis Code</b><br>_____ |
|                                                         | <b>Lactating</b> Yes No |                                                                   |                                         |
|                                                         | _____                   |                                                                   |                                         |

**Radiology Use Only**

Procedure scheduled for: Date \_\_\_\_\_ Time \_\_\_\_\_

Flouro Time \_\_\_\_\_ Actual Date of Procedure \_\_\_\_\_ Actual Time of Procedure \_\_\_\_\_

Room \_\_\_\_\_ Technologist/Sonographer \_\_\_\_\_ Physician \_\_\_\_\_

No. of Images \_\_\_\_\_ Contrast \_\_\_\_\_ Notes \_\_\_\_\_

**Nuclear Medicine/ PET Use Only**

Radiopharmaceutical Administerd \_\_\_\_\_ Date \_\_\_\_\_ By \_\_\_\_\_

Amount \_\_\_\_\_ Time \_\_\_\_\_ Route of Administration \_\_\_\_\_ IV \_\_\_\_\_ Oral \_\_\_\_\_ Other \_\_\_\_\_

Other Agents Administered \_\_\_\_\_ Date \_\_\_\_\_ By \_\_\_\_\_

Amount \_\_\_\_\_ Time \_\_\_\_\_ Route of Administration \_\_\_\_\_ IV \_\_\_\_\_ Oral \_\_\_\_\_ Other \_\_\_\_\_

Physician's Radiopharmaceutical/Adjunct Drug Prescriptions

Outpatient

Inpatient

Technologist's  
Signature \_\_\_\_\_