**CT ORDER**

Patient Name_________________________________________ Date of Birth_________ Phone (H)________________________

Address__________________________________________________________________________________________ Work #________________________

Appointment Date & Time_________________________________________ Referral #________________________ Cell #________________________

Examination Requested______________________________________________________________

☐ 3D reformat images at Radiologist discretion    ☐ Contrast at Radiologist discretion

☐ Perform blood creatinine per RAOT protocol if no labs done within 6 weeks* of scheduled study if patient has HTN, diabetes, single kidney, renal cancer, lupus, liver disease, or is 60 years or older.

*If patient has had blood creatinine labs within 6 weeks, please fax results to RAOT.

Pertinent History____________________________________________________________________________________

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____________________________________________________________________________________________________

ICD-9 Code(s)___________________________________________

**IMPORTANT: MUST BRING THIS FORM WITH YOU TO YOUR APPOINTMENT!!**
Please do not bring children to be left unattended.

___________________________________________
Physician’s Signature

PLEASE FAX COPY TO RADIOLOGY ASSOCIATES AND GIVE PATIENT A COPY