Wahiawa General Hospital
"Never Out Of Touch"

Patient Label

DIAGNOSTIC IMAGING
OUTPATIENT SERVICES REQUISITION

128 Lehua Street, Wahiawa 96786

Revised 10/2021

Imaging Phone: (808) 621-4330
Fax Imaging Orders: (808) 621-4334
Mammography Phone: (808) 621-4177
Fax Mammogram Orders: (808) 621-4106

PATIENT'S LAST NAME:	**FIRST NAME:**	
PHONE NUMBER:	**DOB:**	**SEX:**
INSURANCE/PRE-AUTHORIZATION NUMBER:		
☐ **WET READ** ☐ **STAT**		
DATE OF SERVICE/APPOINTMENT:		
DATE OF INJURY/ONSET:	**LMP DATE:**	

REQUIRED - ICD-10 Diagnosis Code:

REQUIRED - Type of Service/Procedure:

Appropriate Use Criteria (AUC) Consultation (effective 1/1/22) - Mandatory for CT and NM

REQUIRED - HCPCS Code/Modifier:

Decision Support Number (DSN):

DIAGNOSTIC IMAGING

☐ **X-RAY**
☐ RIGHT ☐ LEFT ☐ BILATERAL

☐ **CT** ☐ **CTA**
COMPLETE CT DATA & INDICATORS LISTED BELOW

MAMMOGRAPHY

☐ **Screening Mammo**
☐ **Diagnostic Mammo**
☐ RIGHT
☐ LEFT
☐ BILATERAL

☐ **DEXA**

☐ **NUCLEAR MEDICINE**

☐ **ULTRASOUND**

☐ **OTHER:**_____

PATHOLOGY *(If indicated for Biopsy)*

☐ **Pathology/Cytology**
Site:

CT DATA

- Date of Previous CT:_____
- Is IV contrast required for the procedure?
  ☐ YES ☐ NO ☐ PER RADIOLOGIST
- Creatinine Results:_____ ▪ BUN Results:_____

***Creatinine & BUN Results MUST be within the past 60 days**

- HX of Adverse Drug Reaction to Contrast Media: ☐ YES ☐ NO
- Patient Taking Drug Glucophage (Metformin): ☐ YES ☐ NO

***If yes, the drug should be stopped at the time of or prior to the procedure and 48 hours after contrast media procedure.**

CT INDICATORS

☐ Anemia ☐ Comatose ☐ Concussion ☐ Drainage ☐ GI Bleeding
☐ Hearing Loss ☐ Jaundice ☐ Lymph Nodes ☐ Needle Aspiration
☐ Needle Biopsy ☐ New Onset Seizure ☐ Therapy Planning ☐ TIA
☐ Trauma ☐ Other:_____

SPECIAL INSTRUCTIONS

☐ Patient to Return with Films/CD
☐ Patient may Leave; Return to My Office; Send films/CD to my Office
☐ Send Results By: FAX#_____PHONE #_____

Signature:_____,MD **Print Name:**_____,MD **Date:**_____

Notification to Physicians and Other Persons Legally Authorized to Order Tests for Which Medicare Reimbursement Will Be Sought. *Medicare will pay only for tests that meet the Medicare coverage criteria and are reasonable and necessary to treat or diagnose an individual patient. Medicare does not pay for tests for which documentation, including the patient record, does not support that the tests were reasonable and necessary. Medicare generally does not cover routine screening tests. Complete the ABN for tests that Medicare will not consider "medically necessary" for the noted diagnosis. Procedures governed by local or national coverage determination (LCD or NCD) are found in the Medicare A and Medicare B publications and listed on there respective websites: www.iamedicare.com (Part A) and www.noridianmedicare.com (Part B).*