Dakota RADIOLOGY

Brian R. Baxter, M.D.
Ronald N. Baxter, M.D.
Rebecca L. Belsaas, M.D.
Robert A. Durst, Jr. M.D.
Leo P. Flynn, M.D.
Timothy R. Frost, M.D.
Thomas G. Habbe, M.D.
Gregory D. Saffell, M.D.
Janet R. Shaefer, M.D.
Jon R. Stenberg, M.D.
Charles V. Voigt, M.D.
David K. White, M.D.
William R. Zavitz, M.D.

Patient Name: ______________________ (Last / First / MI) DOB: __________ Home Phone: __________

Patient Insurance: __________ Authorization#: __________ Daytime Phone: __________

Medical Necessity (Required): ______________________________

______________________________ Appointment Date/Time: __________

(Must include pertinent clinical history. "Rule out or suspected" diagnosis alone is not sufficient.)

PET/CT

Brain PET/CT __
Cardiac Viability PET/CT __
Oncology PET/CT __

Diagnosis__
Initial Staging__
Response to Therapy__
Restaging__

Cancer Type __________

CT

Head__
Soft Tissue Neck__
Sinus__
Chest__
PE Study (Chest CTA)__
High Resolution Chest__
Abdomen/Pelvis__
Renal Stone Protocol__
Appendicitis Protocol__
Abdomen__
Pancreas Protocol(Abdomen)__
Pelvis__
Extremity RT LT __
specify: ________

CT Spine w/o contrast__
__CSP __TSP __LSP

CT w/ Intrathecal contrast__
__CSP __TSP __LSP

CT Colonography__
CT Enterography__
CT Urogram__
CT Arthrogram__
Area__________

------------CTA-------------

Brain (Circle of Willis)__
Carotid__
Renal__
Runoff__
Chest__
Chest/Abdomen__
Chest/Abdomen/Pelvis__
Pre-op AAA Stent Protocol__
Post-op AAA Stent Protocol__

Other ____________________

MRI

__Brain
__Breast w/CAD review
__MRI-Guided Breast Biopsy
__IAC
__Pituitary
__Orbit
__Liver
__Renal MR/MRA
__Adrenal
__MRCP
__C-Spine
__T-Spine
__L-Spine
__Pelvis - Bone
__Pelvis - Oncology
__Neck (soft tissue)
__Knee RT LT
__Hip RT LT
__Shoulder RT LT
__Ankle RT LT
__Foot RT LT
__Wrist RT LT
__Elbow RT LT

__MRA
__COW
__Carotid
__Aorta
__Renal
__Runoff
__MRV __________
__MR Arthrogram
Area __________

__Other__________

Venous Insufficiency Consultation

__Vein Screening, physician consultation and necessary treatment including endovenous laser ablation.
__Right
__Left
__Bilateral

Diagnosis:
__Venous Insufficiency
__Venous Ulcers
__Varicose Veins
__Leg Pain
__Other__________

__ 1 month follow-up
__ 5 day follow-up

Ultrasound

__Abdomen Limited - Rt Upper Quadrant
__Abdomen Complete
__Abdomen Aorta
__Bladder
__Carotid
__Follicle Study - Transvaginal
__OB
__Anatomical Survey
__Follow-up
__Transvaginal
__Biophysical Profile
__Umbilical Cord Doppler
__Pelvis / Transvaginal with doppler as deemed necessary by radiologist
__Renal
__Renal Artery Doppler
__Sonohysterogram
__Testicular with doppler as deemed necessary by radiologist
__Thyroid
__Thyroid Biopsy
__Venous Leg (DVT) RT LT BI
__Venous Arm (DVT) RT LT BI
__Arterial Leg RT LT BI
__Other:__________

For breast, use Diagnostic Breast Evaluation section

XRay

__Type __________
____

DEXA Bone Densitometry

__DEXA (Osteoporosis Evaluation)

Interventional

__Lumbar Epidural Steroid Injection
__Facet Injection
Level __________
__Joint Injection
__SI
__Hip
__Shoulder
__Ankle
__Wrist
__Other
__Catheter Injection
__Arthrogram __________

__Lumbar Puncture
Labs __________
____

Breast Imaging Studies

If your patient is due for annual screening, both breasts will be imaged.

__ **Screening Mammogram**
(No symptoms)

__ **Diagnostic Mammogram**
(Ultrasound and Biopsy as Needed)
__Left __Right __Bilateral

__ Clinical Finding:__________
__ Add Views - abnormal mammo
__ 6 Month Follw-up

__ **Breast Ultrasound**
(Mammogram & Biopsy as Needed)
__Left __Right __Bilateral

Breast Biopsy / Localization

__ **Breast Biopsy (US or Stereo)**
__Left __Right __Bilateral

__ **Needle Localization**
__Left __Right __Bilateral

__ **Cyst Aspiration**
__Left __Right __Bilateral

__ **Ductogram**
__Left __Right __Bilateral

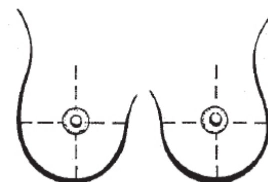
Targeted Studies

Following abnormal breast MRI:

__ **Targeted Breast Ultrasound**
(Biopsy as Needed)
__Left __Right __Bilateral

__ **Target Breast Additional Views**
(Biopsy as Needed)
__Left __Right __Bilateral

Area of Concern



Reporting: ☐ Standard ☐ STAT ☐ Keep patient / Call Results to: __________ Phone: __________
☐ Send Images ☐ Fax Results to: __________

Physician (Please Print) __________ Physician Signature (Required) __________ Date __________

2929 5th Street, Ste 100 / Rapid City, SD 57701 / 605.721.8626 / 800.456.1361 tf / 605.721.8805 fax

www.dakota-radiology.com

© Dakota Radiology

03/15/13 Rev 19