DIAGNOSTIC IMAGING ORDER FORM

To arrange an appointment, please contact the access team via the number below.
UAB Medicine Imaging Appointments: 205.801.8750

Patient Legal Name: _____

Preferred Name (if different from legal name): _____

Select a Preference: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Their

Date of Birth: _____

Patient Phone Number: _____

Patient Email: _____

Reason for Exam: _____

Signs and Symptoms: _____

ICD-10 Code: _____ CPT Code: _____

Insurance Information (Group/Claim#): _____

Pre Cert/Auth#: _____

Effective Date: _____ Expiration Date: _____

DIAGNOSTIC IMAGING:

☐ Radiology (X-ray) ☐ CT ☐ Fluoroscope (GI) ☐ Ultrasound ☐ MRI ☐ Mammography

☐ Angiography ☐ Bone Density (DEXA) – *For a Nuclear Medicine Bone Scan, please call 205-975-8326*

☐ Other: _____

PLEASE SELECT AN IMAGING LOCATION:

☐ **UAB Medicine Leeds**
1141 Payton Way
Leeds, AL 35094
Hours: 8 am–5 pm, Monday through Friday
Imaging services offered: X-ray, Mammogram, Ultrasound, MRI, CT scans

☐ **Gardendale Primary & Specialty Care**
960 Rocket Way
Gardendale, AL 35071
Hours: 8 am–5 pm, Monday through Friday
Imaging services offered: X-ray, Mammogram, Ultrasound, MRI, CT scans

continued on other side

DIAGNOSTIC IMAGING ORDER FORM, cont.

☐ **The Kirklin Clinic of UAB Hospital**
2000 6th Ave. South
Birmingham, AL 35233
Hours: 7 am–7 pm, Monday through Friday
Imaging services offered: MRI, CT scans, Ultrasound, Diagnostic radiology, Gastrointestinal (GI) radiology, Screening and diagnostic mammograms & procedures

☐ **Hoover Primary & Specialty Care**
501 Emery Drive West
Hoover, AL 35244
Hours: 8 am–5 pm, Monday through Friday
Imaging services offered: X-ray, Mammogram, Ultrasound

☐ **UAB Hospital-Highlands**
1201 11th Ave. South
Birmingham, AL 35205
Hours: 7 am–5 pm, Monday through Friday
Imaging services offered: MRI, CT Scans, Ultrasound, Diagnostic Radiology

☐ **First Available. No Preference.**

Area(s) to be Imaged: _____

Biopsy or Aspiration: _____

Iodinated Contrast: ☐ With ☐ Without ☐ With and Without

Gadolinium Contrast: ☐ With ☐ Without ☐ With and Without

Creatine (value, date, if available): _____

Allergies: _____

Physician Name/NPI #: _____

Clinic Contact: _____

Phone Number: _____

Fax Number: _____

Patient Signature: _____ Date:_____