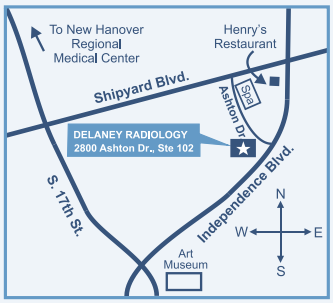

❑ 1025 Medical Center Drive
Wilmington, NC 28401

Delaney Radiology

# RADIOLOGY REFERRAL FORM

**FOR ALL SCHEDULING**
**Phone: (910) 762-3882 or Fax: (910) 762-6739**
**www.delaneyrad.com**




❑ 2800 Ashton Drive Ste. 102
Wilmington, NC 28412

**DELANEY NO.** _____ Today's Date _____

PATIENT'S NAME _____ D.O.B. _____ PHONE _____

DATE OF APPOINTMENT _____ TIME _____

PRIMARY INSURANCE _____ GROUP # _____ AUTH. # _____

SECONDARY INSURANCE _____ GROUP # _____ AUTH. # _____

**PHYSICIAN'S SIGNATURE** *X* _____ **PRINTED NAME** _____

EXAM REQUESTED _____

DIAGNOSIS AND/OR CLINICAL SIGNS OR SYMPTOMS **(DO NOT USE R/O)** _____

_____

FOR CT EXAMS, LIST ALL KNOWN ALLERGIES _____

KNOWN HISTORY OF IV CONTRAST ALLERGY ❑ YES ❑ NO

## MEDICARE ONLY

**WHAT CLINICAL DECISION SUPPORT MECHANISM WAS USED (G-CODE)?** _____
**WHICH AUC CODE WAS GIVEN (HCPCS MODIFIER)?** _____

## CREATININE TESTING

For exams requiring IV contrast, a serum creatinine level within the last 30 days is required for patients with any of the following:

- ❑ Age >60
- ❑ Diabetes
- ❑ Hypertension (or meds for HTN)
- ❑ Renal Dialysis
- ❑ Kidney Disease / Solitary Kidney
- ❑ Chemotherapy (within last 30 days)
- ❑ Sickle Cell Anemia
- ❑ Multiple Myeloma
- ❑ Pheochromocytoma
- ❑ History of severe liver disease, transplant, pending transplant **(Istat same day as MR or CT)**
- ❑ None _____ (initials)
- ❑ **DELANEY TO PROVIDE CREATININE TESTING ON DAY OF EXAM**

_____ **CREATININE** _____ **LOCATION & DATE DRAWN (must be within last 30 days)**

**FOR TECHNOLOGIST USE ONLY** _____ **I-STAT CREATININE**

## Technologist Use Only

Manuf: _____ Lot #: _____ Amount: _____ Exp. Date: _____

Injection Site: _____ Injected by: _____

Post Observation: ❑ Red ❑ Pain ❑ Swelling ❑ Extravasation ❑ None

Send CD: ❑ with patient ❑ other _____

❑ Call report today Phone number _____

❑ Hold patient and call stat report _____

Prior films/testing: where/when? _____

## GFR:

**GFR acceptable range >51**
**GFR 30-50 - half dose**
**GFR < 30 - contact Radiologist**

**Please bring this referral sheet to Delaney Radiologists.**

REV. 6-20

Please bring your insurance information for filing.

# BREAST IMAGING REFERRAL

Delaney Radiology
Women's Imaging Services

1025 Medical Center Drive • Wilmington, NC 28401
Phone: (910) 762-3882 • Fax: (910) 762-6739
www.delaneyrad.com

AMERICAN COLLEGE OF RADIOLOGY ACR AMERICAN COLLEGE OF RADIOLOGY BREAST IMAGING CENTER OF EXCELLENCE

TODAY'S DATE _____

PATIENT'S NAME _____ DOB _____ DELANEY NO. _____

DATE OF APPOINTMENT _____ TIME _____ PT. PHONE _____

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____

**PROVIDER SIGNATURE** *X* _____ **PRINTED NAME** _____

## SCREENING EXAMS

❑ **SCREENING MAMMOGRAM** (Routine exam only - No current problems)
- ❑ Additional imaging if recommended by radiologist
  - ❑ Proceed to biopsy if needed based on further imaging workup

❑ **SCREENING BREAST ULTRASOUND** (Routine screening, dense breasts or family history of breast cancer)
- ❑ Ultrasound guided biopsy and/or aspiration if clinically indicated by the radiologist

## DIAGNOSTIC EXAMS

❑ **COMPREHENSIVE DIAGNOSTIC BREAST IMAGING** (Includes mammogram, ultrasound and/or biopsy if recommended by radiologist)
- ❑ Bilateral ❑ Left ❑ Right

❑ **LIMITED DIAGNOSTIC BREAST IMAGING**

| | | | |
|---|---|---|---|
| ❑ Mammogram with U/S as needed | ❑ Bilateral | ❑ Left | ❑ Right |
| ❑ Mammogram *Only* | ❑ Bilateral | ❑ Left | ❑ Right |
| ❑ Ultrasound *Only* **(LIMITED / COMPLETE)** *circle one* | ❑ Bilateral | ❑ Left | ❑ Right |
| ❑ Stereotactic or U/S Guided Core Biopsy, FNA, Cyst Aspiration *Only* | ❑ Bilateral | ❑ Left | ❑ Right |

❑ **MRI BREAST** *A serum creatinine level within the last 30 days is required for patients with any of the following:*

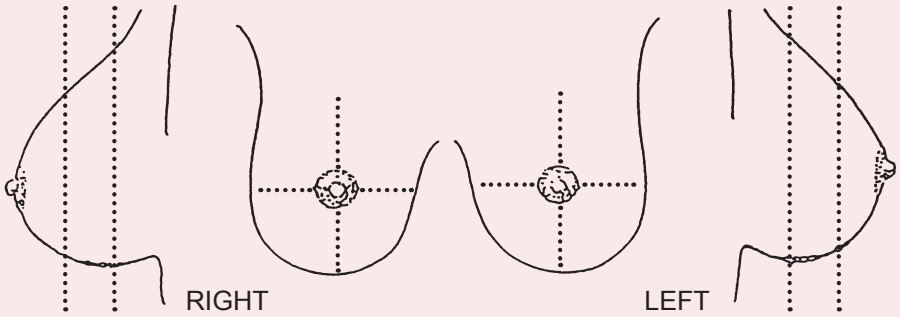
| | | |
|---|---|---|
| ❑ Age >60 | ❑ Renal Dialysis | ❑ Sickle Cell Anemia |
| ❑ Diabetes | ❑ Kidney Disease / Solitary Kidney | ❑ Multiple Myeloma |
| ❑ Hypertension (or meds for HTN) | ❑ Chemotherapy within last 30 days | ❑ Pheochromocytoma |

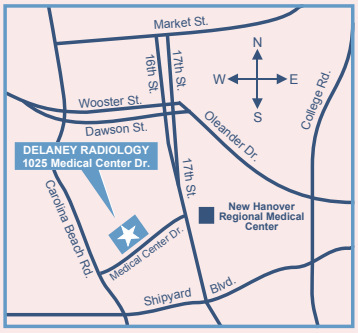
- ❑ History of severe liver disease, transplant, pending transplant **(I-STAT same day as MRI)**
- ❑ **Delaney to provide creatinine testing on day of exam**

**REASON FOR DIAGNOSTIC EXAM** **By selecting one of the options below, this automatically converts a screening exam to a diagnostic exam.**
*(Please use diagram below when appropriate)*

| | |
|---|---|
| ❑ Mass or Lump | ❑ Nipple Discharge: bloody or clear |
| ❑ Calcifications | ❑ Localized Pain |
| ❑ Fibrocystic Changes | ❑ Personal History of Breast Cancer *(within last 5 years)* |
| ❑ Abnormal Prior Mammogram *(radiologist recommended follow-up)* | ❑ Other _____ |

❑ Additional Clinical Information _____




REV. 9-20

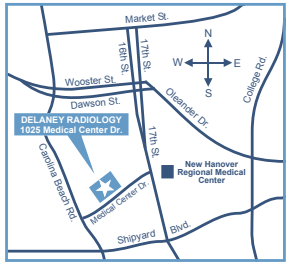
Please bring this referral and your insurance information to your appointment. Please do not use deodorant or powder on breasts or under arm area on the day of your exam.

Delaney Radiology

# DELANEY RADIOLOGY
# BONE DENSITY REFERRAL

**1025 Medical Center Drive • Wilmington, NC 28401**
**Phone: (910) 762-3882 • Fax: (910) 762-6739**
**www.delaneyrad.com**

**FOR ALL SCHEDULING CALL 762-3882 or FAX 762-6739**




**DELANEY NO.** _____ Today's Date _____

PATIENT'S NAME _____ PHONE _____ D.O.B. _____

DATE OF APPOINTMENT _____ TIME _____

PRIMARY INSURANCE _____ GROUP # _____ AUTH. # _____

SECONDARY INSURANCE _____ GROUP # _____ AUTH. # _____

**PHYSICIAN SIGNATURE** $X$ _____ **PRINTED NAME** _____

**BONE DENSITOMETRY (DEXA)** (Lumbar Spine and Hip Scans) CPT 77080 **AND/OR** (FOREARM) CPT 77081

ICD-10 DIAGNOSIS AND/OR CLINICAL SIGNS OR SYMPTOMS _____

## PLEASE CHECK ALL THAT APPLY:

- ☐ Screening for Osteoporosis
- ☐ Postmenopausal surgical
- ☐ Patient is currently getting (or expected to get) glucocorticoid therapy > 3 months
- ☐ Patient is being monitored for FDA approved osteoporosis drug therapy
- ☐ Patient has been determined estrogen deficient and at risk for osteoporosis
- ☐ History of pathological fracture OR traumatic vertebral fracture
- ☐ Patient has hyperparathyroidism
- ☐ Long term use of aromatase inhibitors
- ☐ Postmenopausal age related

### PRIOR SCREENING

Where: _____

When: _____

**PLEASE BRING THIS REFERRAL TO DELANEY RADIOLOGY**

REV. 9-20

Please bring your insurance information for filing. For your comfort, please wear a two piece, elastic waist outfit.

Delaney Radiology

# MRI REFERRAL FORM
## FOR MRI SCHEDULING


**Phone: (910) 762-3882 • Fax: (910) 762-6739**
**www.delaneyrad.com**

☐ **1025 Medical Center Drive**
**Wilmington, NC 28401**

☐ **2800 Ashton Drive Ste. 102**
**Wilmington, NC 28412**


**DELANEY NO.** _____ TODAY'S DATE _____

PATIENT'S NAME _____ D.O.B. _____

PATIENT'S PHONE _____ SECONDARY PHONE _____

PRIMARY INSURANCE _____ GROUP # _____ AUTH. # _____

SECONDARY INSURANCE _____ GROUP # _____ AUTH. # _____

MRI APPOINTMENT DATE _____ TIME _____

**F/UP APPOINTMENT WITH REFERRING: DATE** _____ **TIME** _____

DIAGNOSIS AND/OR CLINICAL SIGNS OR SYMPTOMS **(DO NOT USE R/O)** _____

_____

**PHYSICIAN'S SIGNATURE** *X* _____ **PRINTED NAME** _____

## MEDICARE ONLY

**WHAT CLINICAL DECISION SUPPORT MECHANISM WAS USED (G-CODE)?** _____

**WHICH AUC CODE WAS GIVEN (HCPCS MODIFIER)?** _____

## EXAM(S) REQUESTED

☐ **Without Contrast** ☐ **With / Without Contrast** ☐ **Per Radiologist**

- ☐ MRI Brain
- ☐ MRI Pituitary
- ☐ MRI IACs
- ☐ MRA Brain
- ☐ MRV Brain
- ☐ MRI Neck Soft Tissue
- ☐ MRA Neck
- ☐ MRI Breast
- ☐ MRI Abdomen
- ☐ MRCP
- ☐ MRI Pelvis
- ☐ MRI Pelvis - GYN
- ☐ MRI Prostate
- ☐ MRI Cervical Spine
- ☐ MRI Thoracic Spine
- ☐ MRI Lumbar Spine
- ☐ MRI Sacrum
- ☐ MRI Bony Pelvis
- ☐ MRI Shoulder Left Right
- ☐ MRI Elbow Left Right
- ☐ MRI Wrist Left Right
- ☐ MRI Hand Left Right
- ☐ MRI Hip Left Right
- ☐ MRI Knee Left Right
- ☐ MRI Ankle Left Right (Ankle/Hindfoot)
- ☐ MRI Foot Left Right (Forefoot/Midfoot)

Other _____

**Radiologist's Protocol** _____

_____

## CREATININE TESTING

For MR exams requiring IV contrast, a serum creatinine level within the last 30 days is required for patients with any of the following:

- ☐ Age >60
- ☐ Diabetes
- ☐ Hypertension (or meds for HTN)
- ☐ History of severe liver disease, transplant, pending transplant **(Istat same day as MR)**
- ☐ Renal Dialysis
- ☐ Kidney Disease / Solitary Kidney
- ☐ Chemotherapy (within last 30 days)
- ☐ Sickle Cell Anemia
- ☐ Multiple Myeloma
- ☐ Pheochromocytoma
- ☐ None _____ (initials)

☐ **DELANEY TO PROVIDE CREATININE TESTING ON DAY OF EXAM**

_____ **CREATININE** _____ **LOCATION & DATE DRAWN (must be within last 30 days)**

**FOR TECHNOLOGIST USE ONLY** _____ **I-STAT CREATININE**

PREVIOUS X-RAYS, CT, OR MRI: ☐ Yes ☐ No ☐ Patient to bring ☐ Will send by courier

Where / When? _____

Send Films / CDs to: ☐ Referring MD Office ☐ Other _____

**GFR:**

**GFR acceptable range >51**
**GFR 30-50 - half dose**
**GFR < 30 - contact Radiologist**

REV. 6-20

**IMPORTANT:** If you cannot meet your appointment, please notify our office 24 hours in advance.

# ULTRASOUND REFERRAL

Delaney Radiology
1025 Medical Center Drive
Wilmington, NC 28401
Phone (910) 762-3882
Fax (910) 762-6739

Patient Name _____ Delaney No. _____
Patient Phone _____ D.O.B. _____ Date _____
Appointment Date _____ Time _____
Referring Physician Print _____
Referring Physician Signature _____
Diagnosis and/or Clinical Signs or Symptoms _____
_____

## Exam Requested

| | | | | | |
|---|---|---|---|---|---|
| | Abdomen Limited | 76705 | | Ankle Brachial Indices | 93922 |
| | Abdomen Complete | 76700 | | Duplex Bilateral Arterial Lower Extremities w/ ABI (93925 & 93922) | 93925ABI |
| | Carotid Duplex | 93880 | | Duplex Bilateral Arterial Lower Extremities | 93925 |
| | Renal Transplant | 76776 | | | |
| | Renal Artery Duplex | 93975 | | Bilateral Venous Lower Extremities | 93970Lower |
| | Retroperitoneal Complete, Renal | 76770 | | Venous Lower Extremity-Right | 93971RL |
| | Scrotal With Duplex (76870 & 93976) | 76870Duplex | | Venous Lower Extremity-Left | 93971LL |
| | Transvaginal (only) | 76830 | | | |
| | Pelvis Complete (only) | 76856 | | Bilateral Venous Upper Extremities | 93970Upper |
| | Pelvis Limited | 76857 | | Venous Upper Extremity-Right | 93971RU |
| | Pelvis Complete and Transvaginal (76856 & 76830) | 76856PUS | | Venous Upper Extremity-Left | 93971 LU |
| | Soft Tissue Head/Neck | 76536 | | | |
| | Hepatic Duplex | 93975H | | AAA Screening | 76706 |
| | | | | Retroperitoneal Limited, Aorta | 76775 |
| | Complete Breast (entire breast)-Right | 76641R | | Duplex of Aorta, IVC or Iliac Arteries | 93978 |
| | Complete Breast (entire breast) -Left | 76641L | | | |
| | Limited Breast (focal area of concern) -Right | 76642R | | | |
| | Limited Breast (focal area of concern) -Left | 76642L | | | |

**Other Exam Not Listed:** _____
_____
_____

☐Send CD with Patient ☐ Other Instructions_____
☐ Call Report Today, Phone Number: _____
☐ Hold Patient and Call STAT Report, Phone Number: _____
☐ Prior Films/Testing: _____

Please bring this referral sheet to Delaney Radiologists

Rev. 3/20/19

# UROLOGY REFERRAL

Delaney Radiology

1025 Medical Center Drive
Wilmington, NC 28401
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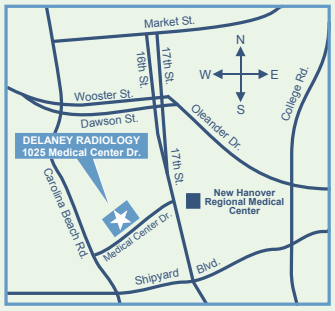
www.delaneyrad.com




**DELANEY NO.** _____ Today's Date _____

PATIENT'S NAME _____ PHONE _____ D.O.B. _____

DATE OF APPOINTMENT _____ TIME _____

PRIMARY INSURANCE _____ GROUP # _____ AUTH. # _____

SECONDARY INSURANCE _____ GROUP # _____ AUTH. # _____

**PHYSICIAN SIGNATURE** *X* _____ **PRINTED NAME** _____

DIAGNOSIS AND/OR CLINICAL SIGNS OR SYMPTOMS _____

**(DO NOT USE R/O)**

KNOWN HISTORY OF IV CONTRAST ALLERGY ❑ YES ❑ NO

## MEDICARE ONLY

**WHAT CLINICAL DECISION SUPPORT MECHANISM WAS USED (G-CODE)?** _____

**WHICH AUC CODE WAS GIVEN (HCPCS MODIFIER)?** _____

## CREATININE TESTING

For exams requiring IV contrast, a serum creatinine level within the last 30 days is required for patients with any of the following:

❑ Diabetes ❑ Renal Dialysis ❑ Sickle Cell Anemia
❑ Hypertension (or meds for HTN) ❑ Kidney Disease / Solitary Kidney ❑ Multiple Myeloma
❑ Chemotherapy (within last 30 days) ❑ Pheochromocytoma ❑ None _____ (initials)

_____ CREATININE _____ LOCATION & DATE DRAWN (must be within last 30 days)

❑ **DELANEY TO PROVIDE CREATININE TESTING ON DAY OF EXAM** _____ I-STAT CREATININE

| | | CPT CODES |
|---|---|---|
| ❑ | **CT RENAL PROTOCOL**<br>CT ABDOMEN AND PELVIS WITHOUT CONTRAST - (RENAL STONE IMAGING)<br>NO PREPARATION | **74176** |
| ❑ | **CT HEMATURIA PROTOCOL**<br>CT ABDOMEN AND PELVIS, WITH AND WITHOUT CONTRAST<br>INCLUDES DIGITAL RECONSTRUCTION OF URETERS<br>NPO 4 HOURS PRIOR TO EXAM AND LABS IF NEEDED | **74178** |
| ❑ | **CT RENAL MASS PROTOCOL**<br>CT ABDOMEN WITH AND WITHOUT CONTRAST - (NO PELVIC IMAGING)<br>NPO 4 HOURS PRIOR TO EXAM AND LABS IF NEEDED | **74170** |
| ❑ | **CT RENAL ANGIO PROTOCOL**<br>CT ANGIO OF THE ABDOMEN WITH AND WITHOUT CONTRAST<br>NO PELVIC IMAGING - INCLUDES DIGITAL RECONSTRUCTION OF VESSELS<br>NPO 4 HOURS PRIOR TO EXAM AND LABS IF NEEDED | **74175** |
| ❑ | **ULTRASOUND KIDNEYS AND BLADDER**<br>FULL BLADDER UPON ARRIVAL IS REQUIRED | **76770** |
| ❑ | **ULTRASOUND RENAL ARTERIES**<br>(NOTHING AFTER MIDNIGHT AND THE MORNING OF THE EXAM) | **93975** |
| ❑ | **ULTRASOUND RENAL TRANSPLANT** (NO PREPARATION) | **76776** |
| ❑ | **ULTRASOUND SCROTUM/TESTICULAR WITH DUPLEX** (NO PREPARATION) | **76870 & 93976** |
| ❑ | **X-RAY - KUB** (NO PREPARATION) | **74000** |
| ❑ | **MRI PROSTATE** (MULTIPARAMETRIC) (NO PREPARATION) | **72197 PROSTATE** |
| ❑ | OTHER: _____ | |

SEND CD: ❑ WITH PATIENT ❑ OTHER _____

❑ CALL REPORT TODAY - PHONE # _____

❑ HOLD PATIENT AND CALL REPORT ❑ PRIOR FILMS/TESTING: WHERE/WHEN? _____

**Please bring this referral sheet to Delaney Radiology.**

Please bring your insurance information for filing.

REV. 10-20