Radiology Request- Radiology Special Procedures
Scheduling 540-332-4434 **Fax** 540-332-5645

Patient Name _____ DOB _____ Weight _____ Appt. Date/Time _____
Patient Address _____ Phone _____
Insurance _____ Policy #_____ Group # _____
Ins. Subscriber/DOB _____ Relation to Patient _____
Pre-Auth Required: Y ___ N ___ Pre-Auth# _____ Packet Given: Y ___ N ___
Reason for Exam _____

Please Check appropriate box(es):

Exam	CPT	Exam	CPT
☐ **Paracentesis**: volume limit: ____ liters ____ Radiologist discretion Albumin needed Y ___ N ___ (arrange with Infusion Center-send order)	49083	☐ **Indwelling Centesis Catheter Placement** (PleurX tunneled catheter) ___ Pleural L ___ R ___ ___ Abdominal ___ Hospice or Home Health referral initiated	75989 32550 49418
☐ **Thoracentesis:** volume limit: ___ L _____ liters ___ R _____ Radiologist discretion	32555	☐ ___ **Thyroid Biopsy** L ___ R ___ ___ Fine needle aspiration ___ Core ___ Radiologist discretion	10005 76942 60100
☐ **Nephrostogram**(new access)L __ R __ existing access L __ R __	50430 50431	☐ **Thyroid Cyst Aspiration or injection** (specify labs below) L ___ R ___	76942 60300
☐ **Nephrostomy Tube Exchange** L __ R __	50435	☐ **Vertebroplasty-Thoracic** Level(s)_____ (additional levels also precert 22512)	22510
☐ **Nephrostomy Tube Placement** L __ R __	50432	☐ **Vertebroplasty-Lumbar** Level(s) _____ (additional levels also precert 22512)	22511
☐ **Nephrostomy Tube Removal** L __ R __	50389	☐ **Kyphoplasty-Thoracic** Level(s) _____ (additional levels also precert 22515)	22513
☐ **NG Tube Placement**	43752	☐ **Kyphoplasty-Lumbar** Level(s) _____ (additional levels also precert 22515)	22514
☐ **Naso-Jejunal Feeding Tube Placement**	74340 44500	☐ **Sacroplasty** (CT Guided only) (usually self-pay if done as outpatient) Unilateral Bilateral	0200T 0201T
☐ **G/J Tube Position/Function Check**	49465	☐ **Needle Biopsy**, image guided- area to be biopsied: **call 332-4434 for codes**	
☐ **G/J Tube Exchange**	49452		
☐ **CVC Patency Check**	36598	☐ **IVC Filter Placement**	37191
☐ **Other Exam**: (Please specify)			
☐ **Diagnostic tests to be done on specimens:** ___ Fluid profile (includes cytology, C&S, protein, glucose, LDH, WBCD; plus albumin for abdominal fluid) ___Other:			

Wet Read Y ☐ N ☐ Patient leave if negative? Y ☐ N ☐ Results will be faxed

Physician Signature_____ Date_____ Time _____

Aspirin and blood thinners must be stopped prior to appointment. Please call 332-4434 for more information.

Revised June 2021

Augusta HEALTH	**Radiology Request- Radiology Special Procedures** **Scheduling** 540-332-4434 **Fax** 540-332-5645

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☐	**Lumbar Puncture** ___ Diagnostic (list tests in space provided) ___ Therapeutic (chemotherapy) (include instructions) ___ Other	77003 62270 77003 96450 Call for codes	☐ ☐ ☐	**Myelogram-Cervical** CT Cervical Spine w contrast **Myelogram-Thoracic** CT Thoracic Spine w contrast **Myelogram-Lumbar** CT Lumbar Spine w contrast	77003 62284 72126 77003 62284 72129 77003 62284 72132
☐	**Paravertebral Injection: Lumbar** Nerve Root L ___ R ___ Facet Joint L ___ R ___ **Checkmark level(s) below** Additional levels precert 64494	64493	☐	**Paravertebral Injection: Cervical/Thoracic** Nerve Root L ___ R ___ Facet Joint L ___ R ___ **Checkmark level(s) below** Additional levels precert 64491	64490
☐	**Epidural Steroid Injection: Lumbar** Checkmark level(s) below	62323	☐	**Sacroiliac Joint Steroid Injection (CT)** L ___ R ___	27096
☐	Epidural Steroid Inj.: Cervical/Thoracic **Checkmark level(s) below**	62321			

Level: **Cervical** ___ C5-C6 ___ C6-C7 ___ C7-T1 **Thoracic** ___ T6-T7 ___ T7-T8 ___ T8-T9 ___ T9-T10 ___ T10-T11 ___ T11-T12 ___ T12-L1 **Lumbar** ___ L1-L2 ___ L2-L3 ___ L3-L4 ___ L4-L5 ___ L5-S1

Medications to be injected:

___ Marcaine 0.25% ___ ml ___ Radiologist discretion

___ Marcaine 0.5% ___ ml ___ Radiologist discretion

___ Depomedrol 40 mg (0.5 to 1 ml)

___ Depomedrol 80 mg (1 to 2 ml)

___ Celestone (betamethasone) 12 mg (2 ml)

___ Other: include mg **or** % and ml) _____

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___ Meds per Radiologist discretion

Comments/additional Instructions

☐ **Other Exam**: (Please specify)

Wet Read Y ☐ N ☐ Patient leave if negative? Y ☐ N ☐ Results will be faxed

Physician Signature_____ Date_____ Time _____

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