Augusta HEALTH	**Radiology Request-Nuclear Medicine** **Scheduling** 540-332-4400 **Fax** 540-332-4490

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
☐ Bone Marrow Scan	78104	☐ Lung-Ventilation/Perfusion Scan	78582
☐ 3 Phase Bone Scan	78315	☐ Lymphatic Lymph Gland Imaging	78195
☐ 3 Phase Bone with SPECT CT	78830	☐ Lymphoscintigraphy-Melanoma	78195
☐ Bone Scan Limited	78300	☐ Meckel's Bowel Imaging	78290 78445
☐ Bone Scan Limited with SPECT CT	78300, 78830	☐ MIBG Scan with I-123	78075
☐ Bone Scan Ltd Mandible w Quantification	78300, 78835	☐ MUGA-Gated Blood Pool Scan	78472
☐ Bone Scan Whole Body	78306	☐ Octreotide Scan with SPECT	78803
☐ Bone Scan Whole Body w SPECT CT	78306, 78832	☐ Parathyroid with SPECT/CT Sestamibi	78072
☐ Brain SPECT daTscan	78803	☐ Renal Scan with Captopril	78708
☐ CFS Leak Determination	78650	☐ Renal Scan with DMSA SPECT	78803
☐ Cisternogram CSF Flow	78630	☐ Renal Scan with Flow/Function	78707
☐ Gallium Abscess Limited	78800	☐ Renal Scan with Lasix	78708
☐ Gallium Abscess Limited w SPECTCT	78830	☐ Sentinel Node	78195
☐ Gallium Abscess Whole Body (1 day)	78802	☐ Tc-WBC Labeling Scan Whole Body 1 day	78802
☐ Gallium Abscess WB w/ SPECT CT	78832	☐ Tc-WBC Labeling WB with SPECT CT	78830
☐ Gallium Tumor Scan with SPECT CT	78832	☐ Tc-WBC Labeling Scan Limited	78800
☐ Gastric Empty Scan	78264	☐ Tc-WBC Labelling Scan ltd SPECT CT	78830
☐ GI Bleed–Acute Blood Loss	78278	☐ Thyroid Cancer Ablative Dose	79005
☐ Hepatobiliary Scan	78226	☐ Thyroid Thyrogen Stimulated Whole Body	78018
☐ Hepatobiliary Scan with Ejection Fraction (CCK)	78227	☐ Thyroid Tumor Whole Body	78018
☐ Hyperthyroid RX Dose	79005	☐ Thyroid Uptake with Scan	78014
☐ Liver Spleen Scan with SPECT	78803	☐ Ureteral Reflux Study	78740
☐ Liver Vascular Flow w/ SPECT-Tagged RBC	78803	☐ Xofigo Therapy	79101
☐ Therapeutic Consult/Treatment: ___Thyroid-CA ___ Thyroid-Hyper ___ Xofigo ___ Other (please specify) _____			
☐ Other Exam: (Please Specify)			

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

Physician Signature_____ Date_____ Time _____

Revised January 31, 2020, rev 2/22