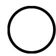
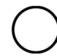
DT18123





Interventional Radiology

☐ **Egleston**
1405 Clifton Road
Atlanta, GA 30322
404-785-2079
FAX: 404-785-6209

☐ **Scottish Rite**
1001 Johnson Ferry Road
Atlanta, GA 30342
404-785-4775
FAX: 404-785-4713

ALL AREAS BELOW IN BOLD ARE REQUIRED

Patient's FULL LEGAL Name	**Date of Birth**	**Phone Number**
Address	**City, State**	**ZIP**
Insurance/Medicaid Plan	**Policy & Group#**	
Authorization# *(Please also fax a copy of insurance card, front and back, with this order)*	Guarantor's Email	

Reason For Exam ***(Signs, Symptoms, Chief Complaint)***

Exam to be Completed
(If procedure is a Lumbar Puncture, Please notate below if opening/closing pressures are necessary along with CSF samples or CSF samples alone.)

Lab Orders
(If any specimens are to go to the lab, please place Lab Orders below. If this section is not completed, no studies will be completed by the lab.)

ALL OFFICE CONTACT INFORMATION REQUESTED IS MANDATORY

Ordering Physician's Printed Name	**Practice Name**	
Ordering Physician's Signature	**Office Contact**	
Date/Time Signed	**Backline Phone**	**Fax**
PCP Name (if different):	**PCP Fax**	

Interventional Radiology

Special Instructions	**Order Comments / Other**
Date / Time Req: ____________________ Confirmed Appt: ____________________ Foster Child: ❑ Yes Contact: ____________________	

Visit choa.org/radiology for a list of CPT codes, ACR ordering guidelines, or to request/print additional forms.

22405-28 (9/15)