Oklahoma Arthritis Center

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Imaging Services Order Form

Patient's Information

Patient's Name:	Patient's Date of Birth:	Patient's Phone:	Gender: M ☐ F ☐
Patient's Address:	Patient's Email:	Insurance:	

Additional Information Needed

☐ Fax front/back of insurance card ☐ Fax clinical/progress notes ☐ Fax labs
☐ Fax patient demographics ☐ Fax current medication list ☐ Fax Imaging Services Order Form

Scheduling Instructions

☐ Preauthorization: ☐ Obtained by referring provider's office ☐ Obtained by Oklahoma Arthritis Center
☐ Insurance Authorization #: ______________________________
☐ Patient Scheduling: ☐ By referring provider's office ☐ By Oklahoma Arthritis Center

Clinical Information

☐ Patient Weight: ___________ lbs / ___________ kg ☐ Patient Height: ___________ in / ___________ cm
☐ Allergies: ____
☐ Other: ____

Patient-Related Questions:

MRI/MRA Questions:

☐ Location of pain? ___________________________________
☐ Surgery in the area of location of pain? ☐ Yes ☐ No
☐ Range of motion limitations? ☐ Yes ☐ No
☐ If "Yes," what limitations(s)? ______________________
☐ How long has pain existed? ___________________________
☐ How did it happen? ___________________________________
☐ Was it an accident? ☐ Yes ☐ No
☐ Medications tried and failed? __________________________
☐ Previous test(s) performed? ☐ Yes ☐ No
☐ If "Yes," what test(s)? ____________________________

Ultrasound Questions:

☐ Will patient be NPO for exam? ☐ Yes ☐ No

X-Ray Questions:

☐ Is patient female? ☐ Yes ☐ No
☐ If "Yes," is patient pregnant? ☐ Yes ☐ No

DEXA Questions:

☐ Date of last DEXA scan? ___________________________
☐ Is patient female? ☐ Yes ☐ No
☐ If "Yes," is patient pregnant? ☐ Yes ☐ No

Image Type and Diagnosis:

☐ MRI: ___________________ Diagnosis (ICD-10): ____
☐ Ultrasound: ______________ Diagnosis (ICD-10): ____
☐ X-Ray: __________________ Diagnosis (ICD-10): ____
☐ Bone Density: ____________ Diagnosis (ICD-10): ____
☐ Special Instructions: ____

Ordering Provider's Information		Ordering Provider's Contact Person
Provider's Name:		Contact's Name:
NPI #:	DEA #:	Contact's Phone:
Provider's Signature:		Contact's Fax:
Date:		

By signing this form, you are authorizing Oklahoma Arthritis Center and its employees to act as your designated agent to interact with medical and prescription insurance companies for prior authorization and specialty pharmacy approval to render infusion services.

American College of Radiology Accredited