



Please fax completed order to 865-381-5652

# Outpatient Center Radiology Order

Patient's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_ DOB \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Pre-Authorization #: \_\_\_\_\_ (If required and not provided, exam may be delayed or rescheduled)

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| <input type="checkbox"/> ABDOMEN-AP & LAT<br><input type="checkbox"/> ABDOMEN-FLAT AND UPRIGHT<br><input type="checkbox"/> ABDOMEN-(KUB)<br><input type="checkbox"/> ANKLE-RIGHT<br><input type="checkbox"/> ANKLE-LEFT<br><input type="checkbox"/> BABYGRAM-AP<br><input type="checkbox"/> BABYGRAM-AP & LAT<br><input type="checkbox"/> BONE AGE BELOW 1 YEAR<br><input type="checkbox"/> BONE AGE OVER 1 YEAR<br><input type="checkbox"/> CHEST-PA<br><input type="checkbox"/> CHEST-PA & LAT<br><input type="checkbox"/> CLAVICLE-RIGHT<br><input type="checkbox"/> CLAVICLE-LEFT<br><input type="checkbox"/> COCCYX<br><input type="checkbox"/> ELBOW-RIGHT<br><input type="checkbox"/> ELBOW-LEFT<br><input type="checkbox"/> FACIAL BONES<br><input type="checkbox"/> FEMUR-RIGHT<br><input type="checkbox"/> FEMUR-LEFT<br><input type="checkbox"/> FINGER-RIGHT<br><input type="checkbox"/> FINGER-LEFT<br><input type="checkbox"/> FOOT-RIGHT<br><input type="checkbox"/> FOOT-LEFT | <input type="checkbox"/> FOREARM-RIGHT<br><input type="checkbox"/> FOREARM-LEFT<br><input type="checkbox"/> HAND-RIGHT<br><input type="checkbox"/> HAND-LEFT<br><input type="checkbox"/> HUMERUS-RIGHT<br><input type="checkbox"/> HUMERUS-LEFT<br><input type="checkbox"/> KNEE-RIGHT<br><input type="checkbox"/> KNEE-LEFT<br><input type="checkbox"/> LEG LOWER TIB-FIB-RIGHT<br><input type="checkbox"/> LEG LOWER TIB-FIB-LEFT<br><input type="checkbox"/> NASAL BONE<br><input type="checkbox"/> NECK SOFT TISSUE-AP & LAT<br><input type="checkbox"/> NECK SOFT TISSUE- LAT ONLY<br><input type="checkbox"/> RIBS 1 SIDE - RIGHT<br><input type="checkbox"/> RIBS 1 SIDE-LEFT<br><input type="checkbox"/> RIBS BILATERAL<br><input type="checkbox"/> OS CALCIS-RIGHT<br><input type="checkbox"/> OS CALCIS-LEFT<br><input type="checkbox"/> PATELLA/SUNRISE 1 VIEW-RIGHT<br><input type="checkbox"/> PATELLA/SUNRISE 1 VIEW-LEFT<br><input type="checkbox"/> PELVIS-AP<br><input type="checkbox"/> PELVIS BILATERAL-(AP & FROG LEG) | <input type="checkbox"/> SACROILIAC JOINTS<br><input type="checkbox"/> SACRUM<br><input type="checkbox"/> SCAPULA-RIGHT<br><input type="checkbox"/> SCAPULA-LEFT<br><input type="checkbox"/> SHOULDER-RIGHT<br><input type="checkbox"/> SHOULDER-LEFT<br><input type="checkbox"/> SKULL COMPLETE-(NON-TRAUMA)<br><input type="checkbox"/> SINUS SERIES - (AP, LAT, & WATERS)<br><input type="checkbox"/> SINUS-(WATERS ONLY)<br><input type="checkbox"/> SPINE CERVICAL 3 VIEW<br><input type="checkbox"/> SPINE CERVICAL 5 VIEW<br><input type="checkbox"/> SPINE CERVICAL 7 VIEW<br><input type="checkbox"/> SPINE THORACIC<br><input type="checkbox"/> SPINE LUMBAR 3 VIEW<br><input type="checkbox"/> SPINE LUMBAR 5 VIEW<br><input type="checkbox"/> SPINE LUMBAR 7 VIEW<br><input type="checkbox"/> STERNOCLAVICULAR JOINTS<br><input type="checkbox"/> STERNUM-AP & LAT<br><input type="checkbox"/> TOES-RIGHT<br><input type="checkbox"/> TOES-LEFT<br><input type="checkbox"/> WRIST-RIGHT<br><input type="checkbox"/> WRIST-LEFT |
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**NOTE:** If you have any questions or are undecided as to which location the testing should be completed, please contact the ETCH Radiology Department at **865-541-8116**.

**Diagnosis** (please write out) & **ICD.10 CODE:**

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**Ordering Provider (Print)** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**North Knoxville**  
 Emory Center  
 207 E. Emory Road  
 Powell, TN 37849  
 Ph: (865) 343-6983

**Sevierville**  
 Sevier Outpatient Center  
 502 Winfield Dunn Pkwy  
 Sevierville, TN 37876  
 Ph: (865) 280-6526

**Blount**  
 Blount Outpatient Center  
 352 Fountain View Circle  
 Alcoa, TN 37701  
 Ph: (865) 518-0995

**Oak Ridge**  
 Oak Ridge Outpatient Center  
 801 Oak Ridge Turnpike  
 Oak Ridge, TN 37830  
 Ph: (865) 689-4041