ARKANSAS MEDICAID EXTENSION OF BENEFITS
RADIOLOGY REFERRAL FORM

Name of Patient | D.O.B. | Medicaid ID#
---|---|---

Reason for Test (Please provide a brief description supporting the reason for ordering the requested testing)


Referring/Ordering Physician’s Name (Please PRINT) | Referring/Ordering Physician’s Medicaid/NPI #
---|---

Referring/Ordering Physician’s Signature | Date of Signature
---|---

Primary Care Physician’s Name (Please PRINT) | PCP Medicaid/NPI #
---|---

### RADIOGRAPHIC EXAMS
- Specify # of views
- Head/neck
- Abdominal
- Spine
- Cervical
- Thoracic
- Lumbar
- Pelvic
- Joint
- RT
- LT
- Bilateral

### RADIOGRAPHIC SPECIAL EXAMS
- Vascular
- Gastrointestinal
- Urinary
- Arthrogram
- Bone Density/Osteoporosis Study

### ULTRASOUND EXAMS
- Head/Neck
- Ophthalmic
- Chest
- Heart
- Aorta
- Abdomen
- Gall Bladder
- Retroperitoneal
- Trans-rectal
- Scrotum
- Non-OB Gynecological
- Extremity
- Other

### CT SCAN (Computed Tomography)
- with contrast
- without contrast
- Brain
- Sinus
- Soft tissue neck
- Chest
- Abdomen
- Pelvis
- Renal stone protocol
- Spine
- Cervical
- Thoracic
- Lumbar
- Joint/Extremity
- CT Angiography
- RT
- LT
- Bilateral (if applicable)
- Other

### MAMMOGRAPHY
- RT
- LT
- Bilateral
- Screening Mammogram
- Diagnostic Mammogram (requires diagnosis)/Ultrasound
- Breast Ultrasound
- Breast procedures (e.g. core biopsy, aspirations, ductogram pre-op localization)

### OTHER
- Bone/Joint
- PET
- Other

### VASCULAR ULTRASOUND
- Carotid Doppler
- Arterial Doppler
- Upper
- Lower
- Venous Doppler
- Upper
- Lower
- RT
- LT
- Bilateral