ARKANSAS MEDICAID EXTENSION OF BENEFITS
RADIOLOGY REFERRAL FORM

_____
Today's Date

_____
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 (specify)_____
☐ Chest ☐ Ribs
☐ Abdominal (specify)_____
☐ Spine ☐ Cervical ☐ Thoracic ☐ Lumbar ☐ Pelvic
☐ Joint _____ ☐ RT ☐ LT ☐Bilateral
☐ Other _____

RADIOGRAPHIC SPECIAL EXAMS
☐ Vascular (specify)_____
☐ Gastrointestinal (specify)_____
☐ Urinary (specify)_____
☐ Arthrogram (specify joint) _____
☐ Bone Density/Osteoporosis Study

ULTRASOUND EXAMS
☐ Head/Neck ☐ Ophthalmic
☐ Chest ☐ Heart ☐ Aorta ☐ Abdomen
☐ Gall Bladder ☐ Retroperitoneal
☐ Trans-rectal ☐ Scrotum
☐ Non-OB Gynecological (specify)_____
☐ Extremity (specify)_____
☐ Other _____

VASCULAR ULTRASOUND
☐ Carotid Doppler
☐ Arterial Doppler ☐ Upper ☐Lower
☐ Venous Doppler ☐Upper ☐Lower ☐RT ☐LT ☐Bilateral

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

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

OTHER
☐ Bone/Joint (specify)_____
☐ PET (specify)_____
☐ Other (specify)
_____
_____