254 Republic Avenue
Joliet, IL 60435
P: 815-730-3344 ● F: 815-730-3888
www.futurediagnosticgroup.com

Imaging for a healthier future
Future Diagnostics Group

ACR American College of Radiology — Breast Imaging Center of Excellence

Advanced Outpatient Diagnostic Imaging Urology Order Form

Patient Name: ______________________________

Age:__________ D.O.B.:______________ Patient Phone:______________________

Referring Physician:______________________ Referring Physician Phone:______________________

Referring Physician Signature:______________________ Referring Physician Fax:______________________

Primary Care Physician:______________________ Primary Care Physician Phone:______________________

Symptoms/Diagnosis: ______________________________

Allergies: ______________________________

Please bring all insurance information with you.
Preparations are required for these exams

To request Pre-Certification, contact us at 815-730-3344 Prompts 7 / 1
Pre-Certification #
____

LAB <u>(required for patient 60 yrs or older or a Diabetic within 60 days)</u>

❑ BUN/Creatinine(GFR)

PET

❑ NaF Bone (r/o Bone Mets) ❑ Axumin (recurrent/Metastatic CA) ❑ Other ______________

NUCLEAR MEDICINE

❑ Whole Body Bone Scan (r/o Bone Mets) ❑ Renal Scan LASIX ❑ Other ______________

CT

❑ CT Abdomen/Pelvis w/Oral Only ❑ CT Abdomen/Pelvis w/IV and Oral
❑ CT Stone Search ❑ CT Urogram w/wo
❑ CT Multi-Phase Kidney ❑ CT Adrenals w/wo ❑ Other ______________

ULTRASOUND

❑ Limited Abdomen (Kidney) ❑ Scrotum Pelvis (Bladder)
❑ Bladder (Pre & Post Void) ❑ Duplex Scan ❑ Other ______________

MRI

❑ Prostate w/wo (Gel Placement) ❑ Prostate w/wo (Lesions/Masses)
❑ Kidney ❑ Soft Tissue Pelvis ❑ Adrenal
❑ Other ______________

X_RAY

❑ KUB ❑ Other ______________

FILM REPORT DELIVERY - ❑ STAT ❑ Give CD to Patient

Additional Instructions or Comments: ______________________________

I hereby authorize Future Diagnostics Group to provided treatment, **release and obtain any previous exams or reports** pertinent to my case in the course of my examination or treatment to my physician, insurance company, adjuster, or attorney, if applicable in this case.

Patient's Signature ______________ **Date** ______

Physician's Signature ______________ **Date** ______

Confidentiality Statement: The information contained in the material is privileged and is intended only for the use of the individual(s) or entity named above. If you are not the intended recipient, be advised that any unauthorized disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited.

Please send all previous exams and reports to our office prior to the schedule exam.