



Office staff calls 865-541-8116 to Schedule Exams  
**PLEASE** fax completed order to Admitting at 865-541-8289  
 Please register in Admitting Monday-Friday 5:30 a.m. - 9 p.m.; Sat. & Sun. 8 a.m. - 4 p.m.  
 After Admitting closes, please register in the ED.

# Radiology Outpatient Orders

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

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

**Fluoroscopy:**

- |  |  |                     |
|--|--|---------------------|
| <input type="checkbox"/> UGI                               | <input type="checkbox"/> Modified Barium Swallow                   | Appt. Date: _____   |
| <input type="checkbox"/> Small Bowel Follow Through (SBFT) | <input type="checkbox"/> Tube Placement: ___NJ ___GJ               | Arrival Time: _____ |
| <input type="checkbox"/> Barium Enema (BE)                 | <input type="checkbox"/> Tube Check: ___NJ ___GJ                   |                     |
| <input type="checkbox"/> Esophagram                        | <input type="checkbox"/> VCUg - Obtain urine specimen UA ___CS ___ |                     |

**Other:** \_\_\_\_\_ **Reason For Exam:** \_\_\_\_\_

**Ultrasound**

- |                                   |   |  |                     |
|-----------------------------------|---|--|---------------------|
| <input type="checkbox"/> Appendix | Duplex (Blood Flow):                      | <input type="checkbox"/> Soft Tissue Extremity (specify)               | Appt. Date: _____   |
| <input type="checkbox"/> Renal    | <input type="checkbox"/> Renal Duplex     | <input type="checkbox"/> Abdomen Limited (Hernia)                      | Arrival Time: _____ |
| <input type="checkbox"/> Pelvis   | <input type="checkbox"/> Pelvic Duplex    | <input type="checkbox"/> Abdomen (includes liver, spleen, gallbladder) |                     |
| <input type="checkbox"/> Pylorus  | <input type="checkbox"/> Scrotum Duplex   | <input type="checkbox"/> Liver   |                     |
| <input type="checkbox"/> Hip      | <input type="checkbox"/> Abdomen Duplex   | <input type="checkbox"/> Spleen  |                     |
| <input type="checkbox"/> Head     | <input type="checkbox"/> Liver Duplex     | <input type="checkbox"/> Gallbladder                                   |                     |
| <input type="checkbox"/> Thyroid  | <input type="checkbox"/> Soft Tissue Neck |  |                     |
| <input type="checkbox"/> Scrotum  |   |  |                     |

**Other:** \_\_\_\_\_ **Reason For Exam:** \_\_\_\_\_

**Nuclear Medicine**

- |   |                                    |                     |
|---|------------------------------------|---------------------|
| <input type="checkbox"/> Gastric Emptying Scan  | <input type="checkbox"/> Bone Scan | Appt. Date: _____   |
| <input type="checkbox"/> Milk Scan  | <input type="checkbox"/> Cystogram | Arrival Time: _____ |
| <input type="checkbox"/> Hida Scan  | Obtain sterile ___UA ___CS         |                     |
| <input type="checkbox"/> Meckels Scan   |                                    |                     |
| <input type="checkbox"/> Renogram; Catheter: <input type="checkbox"/> yes <input type="checkbox"/> no;          | Obtain sterile ___UA ___CS         |                     |
| <input type="checkbox"/> Diuretic Renogram; Catheter: <input type="checkbox"/> yes <input type="checkbox"/> no; | Obtain sterile ___UA ___CS         |                     |

**Other:** \_\_\_\_\_ **Reason For Exam:** \_\_\_\_\_

**CT Scan**

- |  |   |                     |
|--|---|---------------------|
| <input type="checkbox"/> Brain Plain <b>70450</b>                                    | <input type="checkbox"/> Chest Plain <b>71250</b>   | Appt. Date: _____   |
| <input type="checkbox"/> Brain with contrast <b>70460</b>                            | <input type="checkbox"/> Chest with contrast <b>71260</b>                                   | Arrival Time: _____ |
| <input type="checkbox"/> Brain Plain 3-D (Craniosynostosis) <b>(70450 and 76377)</b> | <input type="checkbox"/> Abdomen with contrast (Liver, Pancreas, Kidneys only) <b>74160</b> |                     |
| <input type="checkbox"/> Sinus <b>70486</b>  | <input type="checkbox"/> Abd/Pelvis Plain (Stone Study) <b>74176</b>                        |                     |
| <input type="checkbox"/> Sinus Stealth Series (pre-op) <b>70486</b>                  | <input type="checkbox"/> Abd/Pelvis with contrast (Abd Pain; r/o APPY) <b>74177</b>         |                     |
| <input type="checkbox"/> Temporal Bones/IACs <b>70480</b>                            | <input type="checkbox"/> Abd/Pelvis with contrast/Enterography (Crohn's; IBD) <b>74177</b>  |                     |
| <input type="checkbox"/> Neck with contrast <b>70491</b>                             | <input type="checkbox"/> PE Study (Pulmonary Embolism) <b>71275 &amp; 76377 (3D)</b>        |                     |
|  | <input type="checkbox"/> CTA (vascular study with contrast) of _____                        |                     |

**Other:** \_\_\_\_\_ **CPT Code:** \_\_\_\_\_ **Reason For Exam:** \_\_\_\_\_

**X-Rays (Do not schedule-walk in)**

- |                                      |   |  |  |
|--------------------------------------|---|--|--|
| <input type="checkbox"/> CXR         | <input type="checkbox"/> Bone Age         | <b>Spine:</b> <input type="checkbox"/> Cervical      | <input type="checkbox"/> Extremity ___R ___L (specify) |
| <input type="checkbox"/> KUB         | <input type="checkbox"/> Soft Tissue Neck | <input type="checkbox"/> Thoracic                    |  |
| <input type="checkbox"/> Waters View | <input type="checkbox"/> Pelvis/Hips      | <input type="checkbox"/> Lumbar                      |  |
|                                      |   | <input type="checkbox"/> Scoliosis Series (AP & LAT) |  |

**Other:** \_\_\_\_\_ **Reason For Exam:** \_\_\_\_\_

Ordering Provider (Print) \_\_\_\_\_ (Signature) \_\_\_\_\_ Date \_\_\_\_\_  
 To reorder, please call Physician Services at 865-541-8415

Patient Name: \_\_\_\_\_ Appointment Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Appointment Time: \_\_\_\_\_

Office Address: \_\_\_\_\_

Office Phone: \_\_\_\_\_

# Specialist Referral

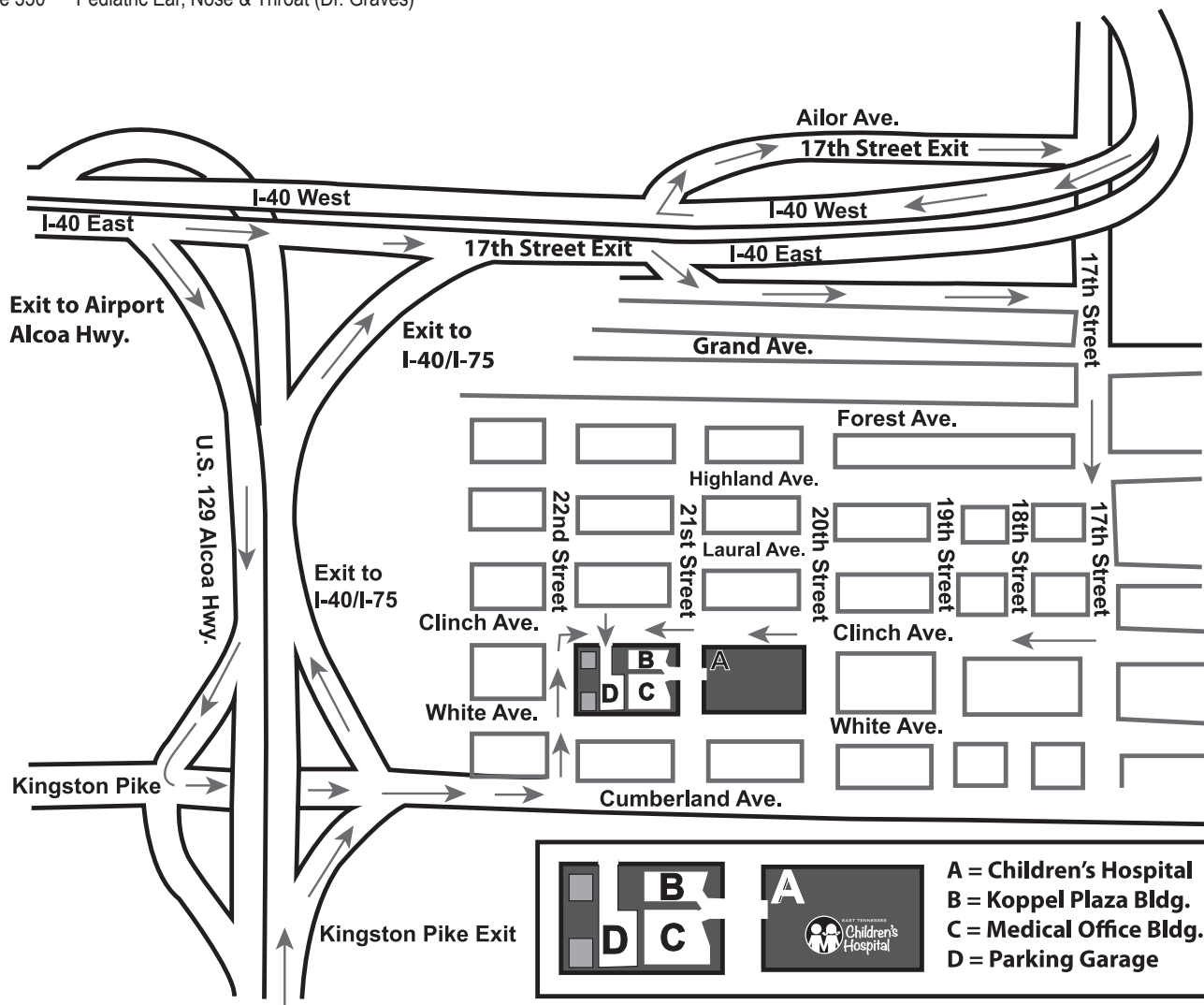
## Medical Office Building (M.O.B.)

- Suite 110 Neurosurgical Associates (Drs. Harris & Savage)
- Suite 120 University Pediatric Urology (Drs. Smith & Aronoff)
- Suite 130 Tennessee Pediatric Urology (Drs. Riden & Angel)
- Suite 140 Pediatric Endocrinology (Drs. Nickels, Tapiador, Wirthwein, Kerrigan & Batajoo)
- Suite 210 Child Neurology (Drs. Gammeltoft, Kosentka, Miller)
- Suite 220 Pediatric Nephrology (Dr. Hopp)
- Suite 230 Pediatric Gastroenterology (Dr. Strobel)
- Suite 310 Pediatric Pulmonology (Drs. Rogers, Riff, Kureshi)
- Suite 330 Pediatric Ear, Nose & Throat (Dr. Graves)

- Suite 410 Children's ENT Specialists (Drs. Little, Belmont, & Ray)
- Suite 430 Children's Pediatric Surgery (Drs. Angel, Jensen, Vaughan)
- Suite 510 GI for Kids (Drs. Al-Tawil, Ammar & DeVoid)

## Koppel Plaza Building

- Suite 420 Knox Pediatric Cardiology (Drs. Jennings, Sharma & Hurst)
- Suite 410 Outpatient Echo Lab
- Suite 400 Pediatric Ophthalmologist (Dr. Gitschlag & Schmitt) and Tots N' Teens Optical



- A** – Children's Hospital Main Entrance is at the corner of Clinch Ave. and 21<sup>st</sup> Street
- B & C** – The Koppel Plaza Bldg. & Medical Office Bldg. are on 21<sup>st</sup> Street - directly across from the Hospital's Main Entrance.
- D** – Children's Parking Garage is located on Clinch Avenue just beyond the Koppel Plaza Bldg.

- For Outpatient Testing:**
- You may park in the Children's Parking Garage, walk up between the Koppel Plaza Building and the Medical Office Building and cross 21<sup>st</sup> Street to enter the main entrance of the Hospital.
  - Register at Outpatient Registration in the Main Hospital Lobby
  - An Admitting Clerk will give you a parking coupon after she enters your information in the computer.