FIRST DAYTON CYBERKNIFE
at First Dayton Cancer Care

DIAGNOSTIC CAT SCAN IMAGING

Phone: (937) 293-2273 Fax Order to: (937) 293-6573
NPI # 1487641585 First Dayton Radiation Oncology

Name:	DOB:	Age:
Phone:	Alt Phone:	
Insurance Name: ID: Group:	Insurance Ph #: Precert #:	
Reason For Exam:		ICD :
Ordering Physician:		
Office Phone:	Office Fax:	
Send Report to:	Office Fax:	
□ Stat: Call Report To:		
Date of Previous CT scan for comparison:	Location:	

* IF PATIENT IS PREGNANT, PLEASE SEND TO ANOTHER FACILITY AS AN ALTERNATIVE MAY BE NEEDED

□ SINUSES	□ ABDOMEN W/O □ Oral Only □ None	□ PELVIS W/O □Oral Only □None
□ FACIAL BONES	□ ABDOMEN WITH □ IV Only □IV & Oral	□ EXTREMITY □ LEFT □ RIGHT SPECIFY:
□ SOFT TISSUE NECK □ W IV CON □ W/O IV CON	□ ABDOMEN/PELVIS W/O □ Oral Only □ None	□ CERVICAL SPINE
□ CHEST □ W IV CON □ W/O IV CON	□ ABDOMEN/PELVIS WITH □ IV Only □IV & Oral	□ THORACIC SPINE
□ CHEST – HIGH RESOLUTION	□ PELVIS WITH □ IV Only □IV & Oral	□ LUMBAR SPINE

IF EXAM IS ORDERED WITH IV CONTRAST PLEASE FILL OUT NEXT SECTION

CHECK ALL THAT APPLY TO THE PATIENT		
□ OVER AGE 70	□ HISTORY OF KIDNEY DISEASE	□ KIDNEY TRANSPLANT
□ NEPHRECTOMY	□ FAMILY HX OF KIDNEY DISEASE	□ DIABETES TYPE 1 OR 2
□ MULTIPLE MYELOMA	□ COLLAGEN VASCULAR DISEASE	□ CONGESTIVE HEART FAILURE
□ CARDIOMYOPATHY	□ HYPERURICEMIA	□ HYPERTENSION
IF ANY ABOVE APPLY PATIENT WILL NEED A CURRENT BUN, CREATININE, AND GFR Within the past 30 days Test Date: BUN Result: Creatinine Result: GFR Result:		

ORDERING PHYSICIAN SIGNATURE **DATE**