CARTI PROSTATE MRI ORDER

Legal Name: Central Arkansas Radiation Therapy Institute
Mailing/Pay: PO Box 55050 • Little Rock, AR 72215
Physical Address: 8901 CARTI Way • Little Rock, AR 72205
Tax ID: 71-0437657 • NPI: 1508147810

Scheduling: 501.296.3253
eFax: 501.537.8786

PATIENT REFERRAL INFORMATION

PATIENT INFORMATION — Please Print

NAME _____

ADDRESS _____

_____

DOB ___/___/_____ EMAIL _____

PHONE _____ SSN _____

CLINIC INFORMATION

REFERRING PROVIDER (Name and NPI#)

_____

_____

FACILITY (Name and address)

_____

_____

_____

PHONE _____

FAX _____

CONTACT NAME _____

PRE-CERTIFICATION

- Our Pre-certification team will obtain all prior authorizations.
- Our imaging schedulers will contact the patient to schedule their appointment and will follow up and mail instructions/map.
- Our imaging schedulers will contact the referring physician's office with the date and time of the patient's appointment.
- Our transcription team will fax the imaging report back to the referring physician's office.

PLEASE FAX THE FOLLOWING DOCUMENTS:

____Signed order

____Signed office note with type of imaging scan in the plan

____All pathology

____All radiology

____Demographic information (face-sheet)

APPOINTMENT DETAILS

DATE _____

TIME _____

PHYSICIAN'S ORDER

TYPE OF EXAM MRI Prostate w/wo w/UroNav w 3D Rendering on Dynacad System

○ WITH CONTRAST ○ WITHOUT CONTRAST ○ WITH AND WITHOUT CONTRAST ○ PORT ACCESS OK

QUALIFYING ICD10 AND DIAGNOSIS _____

ORDERING PHYSICIAN (PRINT) _____

ORDERING PHYSICIAN SIGNATURE _____