MetisMD PRO™
Connected Radiology℠

Radiology Order Form

SCHEDULE EXAM

*Please **fax or email** signed order or script and any other pertinent information: 800-695-8142 email: scheduling@metismd.com

ONLINE www.MetisMD.com *or* **CALL** 800-695-8191 *or* **FAX** 800-695-8142

ATTENTION IMAGING FACILITY: This exam is **ONLY** to be interpreted by a **MetisMD** Radiologist. Please contact us at the number below if MetisMD is not currently a provider at your facility.

PATIENT NAME: _____ DOB: _____

PATIENT PHONE: H: _____ C: _____

REFERRING PROVIDER: _____ EMAIL: _____

OFFICE NUMBER: _____ **DIRECT** LINE OR CELL: _____

EXAM REQUESTED: _____
(For any questions about type of exam to order call MetisMD at 800-695-8191)

MODALITY: MRI CT ULTRASOUND XRAY NUCLEAR MEDICINE ARTHROGRAM (DIRECT / INDIRECT) MAMMOGRAM

BODY SECTION: _____ **RIGHT / LEFT** **IV CONTRAST**: YES NO **ORAL** YES NO

DIAGNOSIS/CLINICAL INDICATION, PERTINENT HX: ☐ Work Injury ☐ MVA ☐ PI **DATE** OF INJURY_____

_____

_____

SPECIAL INSTRUCTIONS OR REQUESTS:

_____

ADDITIONAL SERVICES REQUESTED BY ODERING PROVIDER:

☐ **STAT** OR WET READ WITH CALL (provide direct line or cell: _____)

☐ **TEXT** PRELIM RESULTS TO THIS NUMBER: _____

☐ **ROUTINE** PHONE CONSULT WITH REFERRING PHYSICIAN

☐ **SCREENSHARE** REMOTE INTERACTIVE REVIEW WITH RADIOLOGIST (call to schedule)

☐ **DIRECT** PHONE CONSULTATION BETWEEN RADIOLOGIST AND PATIENT (or 3 way conf. call)

☐ **DC** (CHIROPRACTIC) OR **DPM** (PODIATRIC) RADIOLOGIC INTERPRETATION (CIRCLE ONE)

REPORT DELIVERY: **ONLINE** (call to request secure login) **EMAIL** _____ **FAX** _____

IMAGE DELIVERY: FILMS CD/DVD

REMOTE ACCESS REQUEST (call to arrange)

PROVIDER SIGNATURE: _____ DATE: _____