NPI 1760593347
TIN 82-4890700

Madison Radiology may be listed by site under Guilford Radiology by some insurance networks.

MADISON RADIOLOGY
Imaging Excellence with Personalized Care

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Madison, CT 06443
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www.madisonradiology.com
www.ramradiology.com
www.guilfordradiology.com

Patient's Name _____ **DOB** _____ **Phone #** _____

Insurance _____ **ICD-10 Code / Description** _____ **Authorization #:** _____

BREAST IMAGING	
	Screening Mammogram: R L
	– AVM & US if needed
	– Screening US if dense
	Diagnostic Mammogram: R L
	Screening Breast US R L
	Diagnostic Breast US R L
	Screening Breast MRI
	Breast - Cyst Aspiration R L
	Breast Biopsy R L

ULTRASOUND	
	Carotid 93880
	Venous Doppler - Arm R L
	Venous Doppler - Leg R L
	Abdomen - limited
	Abdomen - complete
	Liver Elastography
	Renal
	Renal & Bladder
	Renal Artery Doppler 93975
	Arterial Extremity _____
	Venous Insufficiency Study
	Pediatrics Hips
	1st Trimester OB
	MSK _____
	Aorta
	Pelvic Transabdominal
	Pelvic Transvaginal
	Testicular
	Thyroid
	Thyroid Biopsy R L
	Soft Tissue
	Doppler

GENERAL X-RAY	
	Chest
	Ribs R L
	Sternum
	KUB
	Abdominal Series
	Sitzmark Study
	Cervical Spine - Complete
	Cervical Spine - AP / LAT
	Thoracic Spine
	Lumbosacral Spine - Complete
	Lumbosacral Spine - AP / LAT
	Sacrum / Coccyx
	SI Joint
	Skull
	Sinuses
	Nasal Bones
	Orbits
	Soft Tissue Neck
	Facial Series
	Mandible
	Mastoids
	Orbits - Pre MRI

GENERAL X-RAY CONT.	
	Clavicle R L
	AC Joints R L
	Scapula R L
	Shoulder R L
	Humerus R L
	Elbow R L
	Forearm R L
	Wrist R L
	Hand R L
	Finger R L
	Pelvis
	Hip R L
	Femur R L
	Knee R L
	Tibia / Fibula R L
	Ankle R L
	Foot R L
	Calcaneus R L
	Toe R L
	Bone Age
	Other

VITAL SCREENING	
	Carotid US
	Abdominal Aorta US

MINIMALLY INVASIVE PAIN MANAGEMENT	
	US Guidance for Soft Tissue Aspiration or Steroid Injection
	Popliteal Cyst
	Greater Trochanter Bursitis
	Subacromial / Subdeltoid Bursitis
	Plantar Fasciitis
	Peroneal Tendonitis
	Lateral Femoral Cutaneous Nerve
	Steroid Joint Injection Joint _____
	Other, please specify

BONE DENSITOMETRY	
	DEXA Bone Densitometry
	DEXA with Forearm
	Body Fat Composition

If STAT, please circle: **STAT & HOLD** **STAT & GO**

REFERRING PROVIDER: _____

DATE: _____ **CONTACT:** _____

CLINICAL INFORMATION: _____

_____

_____

SIGNATURE: _____