



IntelliGuide® PSI CT Scan Order Form

Complete and submit patient information to the imaging center for IntelliGuide® PSI case planning.

Patient Name:

Date of Birth:

Account / MRN #:

Date of Surgery (if known):

Insurance Type:

Practice / Clinic:

Surgeon Name:

Surgeon Phone:

REASON FOR EXAM

☐ Midfoot Deformity

☐ Midfoot Arthritis

☐ Other: _____

EXAM ORDERED

☒ **CT Scan of Affected Foot — Without Contrast CPT 73700**

Weight Bearing or Non-Weight Bearing — entire foot, ≥2cm above ankle joint

Affected Foot: ☐ Right ☐ Left ☐ Bilateral

CT SCAN PARAMETERS — PROVIDE TO IMAGING CENTER

Slice Thickness	≤ 0.75 mm (equal to slice spacing)
Slice Spacing	Contiguous ≤ 0.75 mm (equal to slice thickness)
Pixel Size	≤ 0.75 mm



Please refer to **IntelliGuide® PSI CT Scan Protocol** for more details.

If the imaging center cannot confirm these settings, contact Treace at psirx@treace.net before scanning.

Ordering Provider Signature:

Date:
