PATIENT NAME: _____

MRN: _____

100088

DOB: _____

Medical Imaging Order Form

DATE: _____

*PLEASE NOTE:
E h > Z D / /EDUZ/E &>hKZK^ kZW^z, h> ^ Zs/ dE DKhZ^/> Z E,K^W/d&>hZ/ X
^CHEDULED PROCEDURES REQUIRE AUTHORIZATION PRIOR TO SCHEDULING APPOINTMENT*

LOCATION:_____

W o • µ• E , EW/ íîðññîìïôò

>> ðìórñòórðîïô E & y KDW> d & KAND PROVIDED TO THE PARENT TO BE PRESENT AT THE TIME OF PROCEDURE

CORE/TRUNK

ABDDOMEN		
CHEST		
CHEST/ABDOMEN		
RIBS	R	L
SHOULDER	R	L
STERNUM		
HIP	R	L

SPECIFY VIEWS (IF APPLICABLE):

HEAD

SINUS (WATERS VIEW ONLY)
SINUS SERIES
SKULL
NASAL BONES
FACIAL BONES
ORBITS
SPECIFY VIEWS (IF APPLICABLE):

SPINE

CERVICAL-SPINE
THORACIC-SPINE
LUMBAR-SPINE
SACRUM/COCCYX
SCOLIOSIS
SPECIFY VIEWS (IF APPLICABLE):

UPPER EXTREMITY

HUMERUS	R	L
ELBOW	R	L
RADIUS/ULNA	R	L
WRIST	R	L
SCAPHOID SERIES	R	L
HAND	R	L
FINGER (SPECIFY DIGIT)	R	L

SPECIFY VIEWS (IF APPLICABLE):

LEGEND R = RIGHT L = LEFT

LOWER EXTREMITY

FEMUR	R	L
KNEE	R	L
TIB/FIBULA	R	L
ANKLE	R	L
FOOT	R	L
TOE (SPECIFY DIGIT)	R	L

SPECIFY VIEWS (IF APPLICABLE):

OTHER

SOFT TISSUE NECK (AIRWAYS)
NASOPHARYNX LATERAL (ADENOIDS)
BONE AGE
OTHER:

CARDIOLOGY (Walk-In Service)

ELECTROCARDIOGRAM (ECG)
SPECIFIC INSTRUCTIONS:

BONE SCAN
HIDA (HEPATOBRLIARY) SCAN WITH CHOLECYSTOKININ (CCK)
HIDA (HEPATOBRLIARY) SCAN WITHOUT CHOLECYSTO
LUNG PERFUSION
MECKELS DIVERTICULUM
GASTROINTESTINAL (GI) BLEED
GFR (GLOMERULAR FILTRATION RATE) RENAL
GASTRIC EMPTY - SOLID
GASTRIC EMPTY - LIQUID
MAG3 RENAL WITH LASIX (MERCAPTOACETYLTRIGLYCINE)
DMSA (DIMERCAPTOSUCCINIC ACID) RENAL
SALIVAGRAM

BODY PART(S)

FOR ABDOMINAL:	UPPER	LOWER
IF EXTREMITY:	R	L

SPECIFIC INSTRUCTIONS :

BODY PART(S)

IF EXTREMITY: R L

SPECIFIC INSTRUCTIONS :

BODY PART(S)

IF EXTREMITY: R L

SPECIFIC INSTRUCTIONS :

FLUOROSCOPY (Scheduled Service)

BARIUM ENEMA (BE)
BARIUM ENEMA (BE) WITH AIR CONTRAST
MODIFIED BARIUM SWALLOW
UPPER GI
SMALL BOWEL SERIES
VCUG VOIDING CYSTOURETHROGRAM
CHECK TUBE PLACEMENT

OTHER:

SPECIFIC INSTRUCTIONS :

What is the patient history?_____

_____

When did the symptoms start?_____

Where is the primary focus of the pain/injury? _____ INTERNATIONAL CLASSIFICATION OF DISEASES (ICD) CODE: ____

Special Instructions/Additional Information _____

Office Name _____ Practitioner Name _____

Office Address _____ Telephone _____ Fax_____

Signature / Credentials of ordering Practitioner _____ Date _____ Time _____

Print Name (if different from provider above)_____

:DON ,Q ; UD\ DYDLODEOH 0RQGD\ )ULGD\ D P QRRQ

:DON ,Q (.* DYDLODEOH 0RQGD\ )ULGD\ D P QRRQ

/FNPVST $IJMESFOhT)PTQJUBM MPSJEB

/FNPVST 1BSLXBZ

0SMBOEP

8BML *O BOE 4DIFEVMFE 4FSWJDFT BSF BWBJMBCMF

/FNPVST $IJMESFOhT)FBMUI %PXOUPXO

0SMBOEP

4 0SBOHF "WF

0SMBOEP

8BML *O 93": 8BML *O &,(T

/FNPVST $IJMESFOhT)FBMUI -BLF /BSZ

8-BLF .BSZ #MWE

4VJUF

-BLF .BSZ '-

8BML *O 93": 8BML *O &,(T

/FNPVST $IJMESFOhT)FBMUI MPSJEB

-BLFMBOE)JMMT #MWE 4

-BLFM'BOE

-PDBUFE BU UIF $BSPM +FOLJOT #BSC

-BLFMBOE 3FHJPOBM)FBMUI .FEJDBI

8BML *O 93": 8BML *O &,(T

4DIFEVMFE 6MUSBTPVOET

/FNPVST $IJMESFOhT)FBMUI

/ 8JDLIBN 3E 4UF

.FMCPVSOF

4DIFEVMFE 93": 4DIFEVMFE &,(T

/FNPVST $IJMESFOhT)FBMUI 8JC

%BOJFMT 3E

8JOUIBSEFM

8BML *O 93": 8BML *O &,(T