

PATIENT NAME: _____

MRN: _____

DOB: _____

DATE: _____

LOCATION: _____

100088

Medical Imaging Order Form

*PLEASE NOTE:

Eh > Z D / / EDU/E & > hKZK^ KWz, h > ^ Zs/ dE DKhZ^/> Z EK^W/d&>UZ/ X
^SCHEDULED PROCEDURES REQUIRE AUTHORIZATION AND APPROVAL FROM SCHEDULING APPOINTMENT*

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>> ðíóρñðóρðíîð 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):

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):

BODY PART(S)

FOR ABDOMINAL: UPPER LOWER
IF EXTREMITY: R L

SPECIFIC INSTRUCTIONS :

HEAD

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

OTHER

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

BODY PART(S)

IF EXTREMITY: R L

SPECIFIC INSTRUCTIONS :

CARDIOLOGY (Walk-In Service)

ELECTROCARDIOGRAM (ECG)

SPECIFIC INSTRUCTIONS:

BODY PART(S)

IF EXTREMITY: R L

SPECIFIC INSTRUCTIONS :

SPINE

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

BONE SCAN

HIDA (HEPATOBRILIARY) SCAN WITH CHOLECYSTOKININ (CCK)
HIDA (HEPATOBRILIARY) 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) RENAL
DMSA (DIMERCAPTOSUCCINIC ACID) RENAL
SALIVAGRAM

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 :

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

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) _____

