

Imaging Orders



Patient name: _____ DOB: _____

Referring provider: _____ NPI: _____

Exam date: _____ Symptoms/ICD-10 code: _____

Exam time: _____ Imaging to call Pt to schedule exam Phone: _____

Physician signature for order: _____

EXAM REQUESTED - please mark SITE (region), SIDE (of body)

		GENERAL X-RAY		
No Appointment Needed	<input type="checkbox"/> Chest 2 View (PA/Lat) <input type="checkbox"/> Abdomen 1 V (KUB) <input type="checkbox"/> Abdomen Complete <input type="checkbox"/> C-Spine <input type="checkbox"/> T-Spine <input type="checkbox"/> L-Spine <input type="checkbox"/> T-L Spine <input type="checkbox"/> HUMERUS ___RT ___LT <input type="checkbox"/> SHOULDER ___RT ___LT	<input type="checkbox"/> RIBS ___RT ___LT <input type="checkbox"/> Finger ___RT ___LT Digit 1 2 3 4 5 <input type="checkbox"/> Hand ___RT ___LT <input type="checkbox"/> Wrist ___RT ___LT <input type="checkbox"/> Forearm ___RT ___LT <input type="checkbox"/> Elbow ___RT ___LT <input type="checkbox"/> TOE ___RT ___LT Digit 1 2 3 4 5 <input type="checkbox"/> FOOT ___RT ___LT <input type="checkbox"/> CALCANEOUS ___RT ___LT	<input type="checkbox"/> ANKLE ___RT ___LT <input type="checkbox"/> TIBIA/FIB ___RT ___LT <input type="checkbox"/> KNEE ___RT ___LT <input type="checkbox"/> FEMUR ___RT ___LT <input type="checkbox"/> HIP ___RT ___LT <input type="checkbox"/> PELVIS <input type="checkbox"/> LEG LENGTH <input type="checkbox"/> OTHER _____ <input type="checkbox"/> SPECIAL VIEWS INSTRUCTIONS _____	
	ULTRASOUND			
Scheduled Appointments Required	<input type="checkbox"/> ABDOMEN US COMPLETE <input type="checkbox"/> ABDOMEN US LIMITED <input type="checkbox"/> RENAL <input type="checkbox"/> THYROID <input type="checkbox"/> HEAD & NECK SOFT TISSUE <input type="checkbox"/> PELVIS NON OB <input type="checkbox"/> US INGUINAL HERNIA <input type="checkbox"/> SCROTUM & TESTICULAR <input type="checkbox"/> US PELVIS W TRANSVAG	<input type="checkbox"/> 1ST TRIMESTER WITH ENDOVAGINAL US <input type="checkbox"/> US VASCULAR AORTA <input type="checkbox"/> US VASCULAR CAROTID BILAT <input type="checkbox"/> US VASC. DUPLEX SCAN EXT UNILAT VEINS ___RT ___LT <input type="checkbox"/> US EXTREMITY NON VASCULAR ___RT ___LT <input type="checkbox"/> US HYSTERSONOGRAM <input type="checkbox"/> US VASC. LOW EXT ARTERIAL ___UNITLAT ___BILAT ___RT ___LT <input type="checkbox"/> US VASC. UPPER EX ART. ___UNITLAT ___BILAT ___RT ___LT <input type="checkbox"/> US BREAST ___RT ___LT	<input type="checkbox"/> US AXILLA ___RT ___LT	
	COMPUTED TOMOGRAPHY (CT) - Must be pre-authorized and scheduled			
	(PRE- CT) _____ GFR VALUE _____ DATE DRAWN <input type="checkbox"/> WITH CONTRAST <input type="checkbox"/> WITHOUT CONTRAST <input type="checkbox"/> W&WO CONTRAST	<input type="checkbox"/> ANGIOGRAM specify site _____ <input type="checkbox"/> BRAIN <input type="checkbox"/> NECK <input type="checkbox"/> FACE <input type="checkbox"/> SINUSES <input type="checkbox"/> CHEST <input type="checkbox"/> CHEST/ABD/PELVIS <input type="checkbox"/> ABDOMEN / PELVIS	<input type="checkbox"/> PELVIS <input type="checkbox"/> SPINE CERV___ THOR___ LUMBAR___ <input type="checkbox"/> RENAL COLIC <input type="checkbox"/> HIP <input type="checkbox"/> EXTREM ___RT ___LT <input type="checkbox"/> KNEE ___RT ___LT <input type="checkbox"/> OTHER _____ _____	
MRI - Magnetic Resonance - Must be pre-authorized and scheduled				
<input type="checkbox"/> CONTRAST <input type="checkbox"/> WITHOUT (WO) CONTRAST <input type="checkbox"/> W & WO CONTRAST <input type="checkbox"/> BRAIN <input type="checkbox"/> MRA BRAIN <input type="checkbox"/> IACs	<input type="checkbox"/> MRI FOOT ___RT ___LT <input type="checkbox"/> MRI EXTREMITY KNEE ___RT ___LT <input type="checkbox"/> MRI ANKLE ___RT ___LT <input type="checkbox"/> MRI LOWER EXT ___RT ___LT <input type="checkbox"/> MRI PELVIS <input type="checkbox"/> MRI HIP ___RT ___LT <input type="checkbox"/> MRI ABDOMEN <input type="checkbox"/> MRCP <input type="checkbox"/> MRI ENTEROGRAPHY ABD / PELVIS	<input type="checkbox"/> MRI FINGER Digit 1 2 3 4 5 <input type="checkbox"/> MRI HAND ___RT ___LT <input type="checkbox"/> MRI UPPER EXT ___RT ___LT <input type="checkbox"/> MRI ELBOW ___RT ___LT <input type="checkbox"/> MRI SHOULDER ___RT ___LT <input type="checkbox"/> MRI SPINE ___CERV ___THORAC ___LUMBAR <input type="checkbox"/> BREAST ___BILAT ___RT ___LT		

Fax form back to 360-604-1694