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

☐ Chest 2 View (PA/Lat)	☐ RIBS ____RT ____LT	☐ ANKLE ____RT ____LT
☐ Abdomen 1 V (KUB)	☐ Finger ____RT ____LT Digit 1 2 3 4 5	☐ TIBIA/FIB ____RT ____LT
☐ Abdomen Complete	☐ Hand ____RT ____LT	☐ KNEE ____RT ____LT
☐ C-Spine	☐ Wrist ____RT ____LT	☐ FEMUR ____RT ____LT
☐ T-Spine	☐ Forearm ____RT ____LT	☐ HIP ____RT ____LT
☐ L-Spine	☐ Elbow ____RT ____LT	☐ PELVIS
☐ T-L Spine	☐ TOE ____RT ____LT Digit 1 2 3 4 5	☐ LEG LENGTH
☐ HUMERUS ____RT ____LT	☐ FOOT ____RT ____LT	☐ OTHER ____________________
☐ SHOULDER ____RT ____LT	☐ CALCANEOUS ____RT ____LT	☐ SPECIAL VIEWS
		INSTRUCTIONS ____________________

Scheduled Appointments Required

ULTRASOUND

☐ ABDOMEN US COMPLETE	☐ 1ST TRIMESTER WITH ENDOVAGINAL US	
☐ ABDOMEN US LIMITED	☐ US VASCULAR AORTA	
☐ RENAL	☐ US VASCULAR CAROTID BILAT	
☐ THYROID	☐ US VASC. DUPLEX SCAN EXT UNILAT VEINS	____RT ____LT
☐ HEAD & NECK SOFT TISSUE	☐ US EXTREMITY NON VASCULAR	____RT ____LT
☐ PELVIS NON OB	☐ US HYSTERSONOGRAM	
☐ US INGUINAL HERNIA	☐ US VASC. LOW EXT ARTERIAL	____UNITLAT ____BILAT ____RT ____LT
☐ SCROTUM & TESTICULAR	☐ US VASC. UPPER EX ART.	____UNITLAT ____BILAT ____RT ____LT
☐ US PELVIS W TRANSVAG	☐ US BREAST ____RT ____LT	☐ US AXILLA _______RT ______LT

COMPUTED TOMOGRAPHY (CT) - Must be pre-authorized and scheduled

(PRE- CT)	☐ ANGIOGRAM specify site	☐ PELVIS
__________GFR VALUE	____________________	☐ SPINE CERV____ THOR____ LUMBAR____
___________DATE DRAWN	☐ BRAIN	☐ RENAL COLIC
☐ WITH CONTRAST	☐ NECK	☐ HIP
☐ WITHOUT CONTRAST	☐ FACE	☐ EXTREM ____RT ____LT
☐ W&WO CONTRAST	☐ SINUSES	☐ KNEE ____RT ____LT
	☐ CHEST	☐ OTHER ____________________
	☐ CHEST/ABD/PELVIS	____________________
	☐ ABDOMEN / PELVIS	

MRI - Magnetic Resonance - Must be pre-authorized and scheduled

CONTRAST	☐ MRI FOOT ____RT ____LT	☐ MRI FINGER Digit 1 2 3 4 5
☐ WITHOUT (WO) CONTRAST	☐ MRI EXTREMITY KNEE ____RT ____LT	☐ MRI HAND ____RT ____LT
☐ W & WO CONTRAST	☐ MRI ANKLE ____RT ____LT	☐ MRI UPPER EXT ____RT ____LT
☐ BRAIN	☐ MRI LOWER EXT ____RT ____LT	☐ MRI ELBOW ____RT ____LT
☐ MRA BRAIN	☐ MRI PELVIS	☐ MRI SHOULDER ____RT ____LT
☐ IACs	☐ MRI HIP ____RT ____LT	☐ MRI SPINE
	☐ MRI ABDOMEN	____CERV ____THORAC ____LUMBAR
	☐ MRCP	☐ BREAST ____BILAT ____RT ____LT
	☐ MRI ENTEROGRAPHY ABD / PELVIS	