RADIOLOGY ORDER FORM

Scheduled For:_____

Forks Community Hospital 530 Bogachiel Way, Forks, WA 98331 360-374-6271 x166 Fax 360-374-6084

Patient _____ **Date of Birth** _____ **Patient Phone**_____

Provider Signature _____ **Date**_____ **CT/MRI Authorization #:**_____

Instructions: ☐ Cc Report to:_____ ☐ Call Report ASAP ☐ Call Patient to Schedule Appt

CLINICAL HISTORY/INDICATIONS:_____

_____

X-RAY

☐ Abdomen 1 view-KUB-supine
☐ Abdomen 2 view-upright/supine
☐ Abdomen 3 view-includes CXR
☐ Chest PA & Lateral
☐ Ribs w/ PA Chest (L) (R)
☐ Sternum
☐ Pelvis

SPINE

☐ Cervical Spine-AP,Lat,Odontoid
☐ Cervical Spine w/ Obliques
☐ Cervical w/ Flexion /Extension
☐ Soft Tissue Neck
☐ Thoracic Spine
☐ Lumbar Spine (AP, Lat, Spot)
☐ Lumbar Spine w/ Obliques
☐ Sacrum/Coccyx
☐ Sacroiliac (SI) Joints B/L

UPPER EXTREMITY

☐ Finger / Thumb (L) (R)
☐ Hand (L) (R)
☐ Wrist (L) (R)
☐ Forearm (L) (R)
☐ Elbow (L) (R)
☐ Humerus (L) (R)
☐ Shoulder (L) (R)
☐ Acromioclavicular (AC) Joints
☐ Clavicle (L) (R)
☐ Scapula (L) (R)

LOWER EXTREMITY

☐ Toe(s) (L) (R)
☐ Foot (L) (R)
☐ Calcaneus (L) (R)
☐ Ankle (L) (R)
☐ Tibia/Fibula (lower leg) (L) (R)
☐ Knee (L) (R)
☐ Femur (L) (R)
☐ Hip includes Pelvis (L) (R)

HEAD

☐ Nasal Bones
☐ Orbits for MRI Screening

FLUORO

☐ Esophagram (Barium Swallow)
☐ Upper GI
☐ Small Bowel Follow Through
☐ Barium Enema

DXA- BONE DENSITY

☐ DXA-Bone Density
Prior Exam Date:_____

ULTRASOUND

☐ Abdominal Complete
☐ Abdominal Limited-single organ
☐ Aorta
☐ Arterial Lower Ext (L) (R)
(including Iliacs/Aorta & ABI's pre/post)
☐ Breast (L) (R)
☐ Cardiac Echo
☐ Carotid (Bilateral)
☐ Chest or Pleural Fluid
☐ Extremity (Non-Vascular)
☐ OB < 14 wks + Transvaginal PRN
☐ OB > 14 wks + Transvaginal PRN
☐ OB Biophysical Profile/Umbilical Art
☐ Pelvic TransAbd &/or Transvaginal
☐ Renal
☐ Renal w/ Bladder pre/post Void
☐ Bladder pre/post Void
☐ Scrotum / Testicle
☐ Soft Tissue Neck
☐ Thyroid
☐ Venous (L) (R) _____

MAMMOGRAPHY

☐ Annual Screening
☐ Unilateral Left
☐ Unilateral Right
☐ Diagnostic Bilateral

CT

Specify Contrast for Exam:

☐ As Medically Indicated
☐ With IV Contrast ☐ No IV Contrast
☐ With & w/out IV Contrast
☐ Oral Contrast ☐ Rectal Contrast

Creatinine_____BUN_____

Date Drawn: _____

(within 30 days of scan)

☐ **Lab Order: Creatinine & BUN**

ICD9 Code_____(required for Lab)

☐ Chest ☐ Abd / Pelvis
☐ Abdomen ☐ Pelvis
☐ KUB (kidney stone) w/o contrast
☐ Renal Protocol w/ IV contrast

SPINE

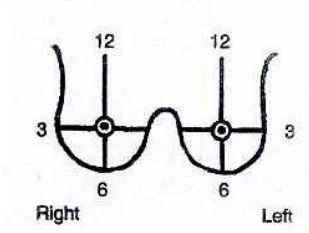
☐ Cervical Spine
☐ Thoracic Spine, Level:_____
☐ Lumbar Spine
☐ Sacrum / Coccyx

HEAD / NECK

☐ Head
☐ Sinuses
☐ Facial Bones
☐ Temporolmandibular TMJ Joints
☐ IAC / Temporal Bones
☐ Soft Tissue Neck

EXTREMITIES

☐ Extremity (L) (R)
Specify Location: _____



MRI

Complete Screening Form on Back

Specify Contrast for Exam:

☐ As Medically Indicated
☐ W/ IV Contrast ☐ No IV Contrast
☐ With & w/out IV Contrast

Creatinine:_____BUN:_____

GFR: _____

Date Drawn: _____

(within 30 days of scan)

*Required for ALL contrast patients

☐ **Lab Order: Creatinine**

ICD9 Code_____(required for Lab)

UPPER EXTREMITY

☐ **Left** ☐ **Right**

☐ Shoulder ☐ Humerus ☐ Elbow
☐ Forearm ☐ Wrist ☐ Hand

LOWER EXTREMITY

☐ **Left** ☐ **Right**

☐ Hip ☐ Femur ☐ Knee
☐ Tibia / Fibula ☐ Ankle ☐ Foot

SPINE

☐ Cervical Spine ☐ Thoracic Spine
☐ Lumbar Spine ☐ Sacrum / Coccyx
☐ Sacroiliac (SI) Joints

HEAD / NECK

☐ Brain ☐ Facial Bones ☐ Pituitary
☐ Temporal Bone / IAC
☐ Temporomandibular TMJ Joints
☐ Soft Tissue Neck ☐ Sella/IAC

OTHER

☐ Chest ☐ Abdomen ☐ Pelvis ☐ Aorta

Any Other Procedure:

_____

_____