

OUTPATIENT TESTING REQUEST FORM

PATIENT NAME: _____ DATE OF BIRTH: _____
 (Last) (First)

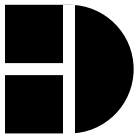
MED REC # _____ Sex: Male Female PRE-CERT # _____

REFERRING PHYSICIAN SIGNATURE: _____ OTHER PHYSICIAN: _____

Please specify reason for exam (clinical history, physical exam, lab findings, etc.) OTHER PHYSICIAN: _____

Date of Exam: _____ Time of Exam: _____ Urgent Interpretation: Yes No

GENERAL RADIOLOGY	GENERAL RADIOLOGY	GENERAL RADIOLOGY	GENERAL RADIOLOGY
Head & Neck	Upper Extremity	Urologic	GI Tract
<input type="checkbox"/> Mandible	Right Left	<input type="checkbox"/> IVP with Tomos	<input type="checkbox"/> Swallowing Study
<input type="checkbox"/> Facial Bones	<input type="checkbox"/> <input type="checkbox"/> Clavicle	<input type="checkbox"/> IVP	<input type="checkbox"/> Esophagus Only
<input type="checkbox"/> Nasal Bones	<input type="checkbox"/> <input type="checkbox"/> Scapula	<input type="checkbox"/> Loopogram	<input type="checkbox"/> GI Series
<input type="checkbox"/> Orbits	<input type="checkbox"/> <input type="checkbox"/> Shoulder	<input type="checkbox"/> Cystogram	<input type="checkbox"/> GI / Small Bowel
<input type="checkbox"/> Sinuses	<input type="checkbox"/> <input type="checkbox"/> A.C. Joints	<input type="checkbox"/> VCUG	<input type="checkbox"/> Small Bowel Only
<input type="checkbox"/> Skull	<input type="checkbox"/> <input type="checkbox"/> Humerus	<input type="checkbox"/> Nephrostogram	<input type="checkbox"/> Barium Enema (air contrast)
<input type="checkbox"/> TMJs	<input type="checkbox"/> <input type="checkbox"/> Elbow	<input type="checkbox"/> Retrograde Urethrogram	<input type="checkbox"/> Barium Enema (no air)
<input type="checkbox"/> Neck Soft Tissue	<input type="checkbox"/> <input type="checkbox"/> Forearm		<input type="checkbox"/> T-Tube Cholang.
<input type="checkbox"/> Foreign Body of Orbit	<input type="checkbox"/> <input type="checkbox"/> Wrist	Spine	<input type="checkbox"/> Enteroclysis (Scheduled after consultation with Radiologist)
<input type="checkbox"/> Sialogram (Scheduled after consultation with Radiologist)	<input type="checkbox"/> <input type="checkbox"/> Hand	<input type="checkbox"/> Cervical	<input type="checkbox"/> Other (Please specify):
	<input type="checkbox"/> <input type="checkbox"/> Finger ()	<input type="checkbox"/> Thoracic	
	<input type="checkbox"/> <input type="checkbox"/> Upper Ext. Child	<input type="checkbox"/> Lumbosacral Spine – 4 views	
		<input type="checkbox"/> Lumbar Spine – AP & Lat. Only	
Chest / Abdomen		<input type="checkbox"/> Sacrum / Coccyx	<input type="checkbox"/> LYMPHANGIOGRAM Consult Radiologist prior to scheduling
<input type="checkbox"/> PA & LAT	Lower Extremity	<input type="checkbox"/> SI Joints	
<input type="checkbox"/> Chest (Single frontal view)	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Scoliosis Series	
<input type="checkbox"/> Decub: R ___ L___ Bilat___	<input type="checkbox"/> Hips (Bilateral)	<input type="checkbox"/> Lat Cer Flex / Ext	MUSCULOSKELETAL
<input type="checkbox"/> Obliques	Right Left	<input type="checkbox"/> Lat Lumb Flex / Ext	<input type="checkbox"/> Arthrogram (Specify joint):
<input type="checkbox"/> Lordotic	<input type="checkbox"/> <input type="checkbox"/> Hip (2 Views)	<input type="checkbox"/> Other: Please specify -e.g. lateral bending	
<input type="checkbox"/> Ribs R ___ L___	<input type="checkbox"/> <input type="checkbox"/> Hip / Pelvis (Chld)		MYELOGRAPHY
<input type="checkbox"/> Bilateral Ribs with Chest PA	<input type="checkbox"/> <input type="checkbox"/> Femur		<input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar
<input type="checkbox"/> Sternum	<input type="checkbox"/> <input type="checkbox"/> Knee		<input type="checkbox"/> Intrathecal Injection
<input type="checkbox"/> Abdomen	<input type="checkbox"/> <input type="checkbox"/> Standing Knees	Miscellaneous	<input type="checkbox"/> CT Myelography (specify location)
<input type="checkbox"/> Abd/KUB	<input type="checkbox"/> <input type="checkbox"/> Tibia	<input type="checkbox"/> Met Series and Chest	
<input type="checkbox"/> Obst Survey - Chest	<input type="checkbox"/> <input type="checkbox"/> Ankle	<input type="checkbox"/> Hysterosalpingogram	MAMMOGRAPHY
<input type="checkbox"/> Obst Survey - No Chest	<input type="checkbox"/> <input type="checkbox"/> Foot	<input type="checkbox"/> Fistulogram	<input type="checkbox"/> Screening
<input type="checkbox"/> Abd Flat & Upright - Chest	<input type="checkbox"/> <input type="checkbox"/> Standing Feet	<input type="checkbox"/> Long Bone Study	<input type="checkbox"/> Unilateral Diagnostic: R ___ L___
<input type="checkbox"/> Abd Flat & Upright - No Chest	<input type="checkbox"/> <input type="checkbox"/> Toe	<input type="checkbox"/> Child Bone Study	<input type="checkbox"/> Bilateral Diagnostic
<input type="checkbox"/> Other (please specify):	<input type="checkbox"/> <input type="checkbox"/> Os Calcis	<input type="checkbox"/> Pediatric Foreign Body	<input type="checkbox"/> Localization
	<input type="checkbox"/> <input type="checkbox"/> Lower Ext. Child	<input type="checkbox"/> Fluoroscopy Only	<input type="checkbox"/> Stereotactic Biopsy
		<input type="checkbox"/> Bone Age	<input type="checkbox"/> Ductogram
		<input type="checkbox"/> Other (please specify):	<input type="checkbox"/> Ultrasound Breast: R ___ L ___ Bilat. ___



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Date of Exam: _____ Time of Exam: _____ Urgent Interpretation: Yes No

ULTRASOUND	CT SCAN	MRI
<input type="checkbox"/> Abdomen / Gall Bladder	Contrast: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Brain
<input type="checkbox"/> Aorta / Inferior Vena Cava	<input type="checkbox"/> Head	<input type="checkbox"/> Orbits
<input type="checkbox"/> Bladder	<input type="checkbox"/> Temporal Bone	<input type="checkbox"/> Neck
<input type="checkbox"/> Breast: R ___ L ___ Bilat. ___	<input type="checkbox"/> Facial Bones / Sinuses / Orbit	<input type="checkbox"/> Pituitary (history of surgery: Yes ___ No ___)
<input type="checkbox"/> Neonatal Head	<input type="checkbox"/> Limited Sinus - Pediatric patients only	<input type="checkbox"/> Breast: R ___ L ___ Bilat. ___
<input type="checkbox"/> Obstetrical	<input type="checkbox"/> Dentascan	<input type="checkbox"/> Cervical Spine
<input type="checkbox"/> Obstetrical with Amnio	<input type="checkbox"/> Neck	<input type="checkbox"/> Thoracic Spine
<input type="checkbox"/> Amniocentesis Only	<input type="checkbox"/> Upper Extremities - Specify which part or joint	<input type="checkbox"/> Lumbar Spine (history of surgery: Yes ___ No ___)
<input type="checkbox"/> Pediatric Hips		Abdomen - please specify below
<input type="checkbox"/> Pelvis - Transabdominal	<input type="checkbox"/> Thorax	<input type="checkbox"/> MRCP only
<input type="checkbox"/> Pelvis - Transvaginal	<input type="checkbox"/> High Resolution Thorax (e.g. interstitial lung disease)	<input type="checkbox"/> MRCP and Pancreas
<input type="checkbox"/> Hysterosonography (Saline Infusion)	<input type="checkbox"/> Abdomen & Pelvis	<input type="checkbox"/> Liver
<input type="checkbox"/> Popliteal Fossa	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Kidneys
<input type="checkbox"/> Prostate - Transrectal (Scheduled in conjunction w/biopsy unless ordered by Urologist)	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Adrenal Glands
<input type="checkbox"/> Renal	<input type="checkbox"/> CT Urogram	<input type="checkbox"/> Abdominal Survey
<input type="checkbox"/> Scrotum	<input type="checkbox"/> CT Stone Study	<input type="checkbox"/> Pelvis
<input type="checkbox"/> Spine (Pediatric)	<input type="checkbox"/> High Resolution Pancreas	Right Left
<input type="checkbox"/> Thyroid / Parathyroid	<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> <input type="checkbox"/> Shoulder
<input type="checkbox"/> Other:	<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/> <input type="checkbox"/> Hip
	<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/> <input type="checkbox"/> Elbow
	<input type="checkbox"/> Lower Extremities (Specify which part or joint)	<input type="checkbox"/> <input type="checkbox"/> Wrist
		<input type="checkbox"/> <input type="checkbox"/> Hand
	<input type="checkbox"/> Other (please specify):	<input type="checkbox"/> <input type="checkbox"/> Knee
VASCULAR ULTRASOUND	CT ANGIOGRAPHY	<input type="checkbox"/> <input type="checkbox"/> Ankle
<input type="checkbox"/> Carotid Doppler	<input type="checkbox"/> Head	<input type="checkbox"/> <input type="checkbox"/> Foot
<input type="checkbox"/> Venous Doppler of _____	<input type="checkbox"/> Neck	<input type="checkbox"/> TMJ
<input type="checkbox"/> Arterial Doppler of _____	<input type="checkbox"/> Thorax	<input type="checkbox"/> Infant (oral sedation)
<input type="checkbox"/> Dialysis Shunt	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Pediatric (anesthesia)
<input type="checkbox"/> By-pass Graft	<input type="checkbox"/> Coronary CTA	<input type="checkbox"/> Other (please specify):
BIOPSY or DRAINAGE	<input type="checkbox"/> Lower Extremities (Specify which part or joint)	
Consult Radiologist prior to scheduling	<input type="checkbox"/> Other (please specify):	
Please circle: Biopsy Drainage		
<i>Procedure</i> <i>MRI</i> <i>U/S</i> <i>CT</i>	Spine	MR ANGIOGRAPHY
<input type="checkbox"/> Breast <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Diskography: specify _____	<input type="checkbox"/> Circle of Willis
<input type="checkbox"/> Thoracentesis <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Facet Joint Injection / Block	<input type="checkbox"/> Carotids
<input type="checkbox"/> Paracentesis <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Epidural or Nerve Sheath Injection	<input type="checkbox"/> Renal Arteries
<input type="checkbox"/> Thyroid <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> CT Myelography (specify location)	<input type="checkbox"/> Other (please specify):
<input type="checkbox"/> Other (please specify) <input type="checkbox"/> <input type="checkbox"/>		