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Patient Name:		DOB:	STAT
Phone:	First Appt Date:	Appt Time: _	TAIGUE ANIGE TAIEC
Special Instructions for Delivery or Patient HC of Report, CD, or Film:			
CHIEF COMPLAINT / WORKING DIAGNOSIS / HISTORY:		FOR MEDICARE MRI AND CT:  G CODE:  MODIFIERS:	
X-RAY / DEXA - BONE D	DENSITY LEFT	RIGHT	WEIGHT-BEARING
<ul> <li>☐ Chest</li> <li>☐ Abdomen Acute Series</li> <li>☐ Abdomen (KUB)</li> <li>☐ Soft Tissue Neck</li> <li>☐ Orbits ☐ Sinuses</li> <li>☐ Ribs</li> <li>☐ DEXA - Bone Densitometry</li> </ul> FLUOROSCOPY	<ul> <li>☐ Cervical Spine</li> <li>☐ Thoracic Spine</li> <li>☐ Lumbar Spine</li> <li>☐ Sacrum</li> <li>☐ Pelvis</li> <li>☐ Scoliosis with stitching</li> <li>☐ Hip</li> </ul>	Shoulder   Humerus   Elbow   Forearm   Wrist   Hand   Fingers	☐ Femur ☐ Knee ☐ Tibia & Fibula ☐ Ankle ☐ Foot ☐ Toes ☐ OTHER:
<ul><li>Esophagram</li><li>ARTHROGRAM - Body Part:</li></ul>	☐ Barium Swallow	□ Upper G.I. Se □ Barium Enem	
MRI LEFT RIGH	T WITH & WITHOUT	CONTRAST W	VITHOUT CONTRAST WITH CONTRAST
<ul> <li>☐ Chest</li> <li>☐ Brain</li> <li>☐ Orbit/Brain (ordered w&amp;wo contrast)</li> <li>☐ Soft Tissue Neck</li> <li>☐ IAC's/Brain (ordered w&amp;wo contrast)</li> <li>☐ Pituitary/Brain (ordered w&amp;wo contrast)</li> <li>☐ Runoff Angiogram</li> <li>☐ MRA (Angiogram)</li> <li>body part:</li> </ul>	<ul> <li>☐ Cervical Spine</li> <li>☐ Thoracic Spine</li> <li>☐ Lumbar Spine</li> <li>☐ Sacrum</li> <li>☐ Pelvis</li> <li>☐ Abdomen</li> <li>☐ Hip</li> <li>☐ ARTHROGRAM - Body</li> </ul>	☐ Shoulder ☐ Humerus ☐ Elbow ☐ Forearm ☐ Wrist ☐ Hand ☐ Fingers Part:	Bun: & Creatinine:    Femur   Knee   Tibia & Fibula   Ankle   Foot   Toes   OTHER:
CT LEFT RIGHT WITH & WITHOUT CONTRAST WITHOUT CONTRAST WITH CONTRAST			
<ul> <li>□ Brain/Head</li> <li>□ Sinus</li> <li>□ Orbits</li> <li>□ Maxillofacial</li> <li>□ Posterior Fossa/I.A.C.</li> <li>□ Chest</li> <li>□ Extremity:</li> </ul>	<ul> <li>☐ Cervical Spine</li> <li>☐ Thoracic Spine</li> <li>☐ Lumbar Spine</li> <li>☐ Abdomen (Does Not Include Pelvis)</li> <li>☐ Abdomen &amp; Pelvis</li> <li>☐ Soft Tissue Neck</li> <li>☐ Renal Stone Protocol (Without Contrast)</li> </ul>	<ul> <li>☐ Head CTA</li> <li>☐ Abdomen CTA</li> <li>☐ Chest CTA</li> <li>☐ Neck CTA (Ca</li> <li>☐ Aorta CTA thor</li> <li>☐ Aorta CTA abdomen</li> <li>☐ Runoff CTA</li> </ul>	☐ Virtual Colonography rotids) ☐ MYELOGRAM Level
ULTRASOUND LEFT RIGHT OB ULTRASOUNDS - TURN TO BACK OF PAGE			
<ul> <li>□ Abdomen</li> <li>□ Upper Abdomen</li> <li>□ Pelvic (includes Transvaginal)</li> <li>□ Renal / Kidneys</li> <li>□ Groin/Inguinal/Hernia (extremity in the content of the conten</li></ul>	circle: leg or arm	<ul> <li>☐ Thyroid</li> <li>☐ Pylorus - for</li> <li>☐ Testicles</li> <li>☐ Aorta</li> <li>☐ OTHER:</li> </ul>	☐ Carotid infant vomiting ☐ Soft Tissue: ☐ Breast
MAMMOGRAPHY	Implants LEFT	RIGHT	
☐ Screening - NO SYMPTOMS	☐ Diagnostic TURN	TO BACK PAGE FO	R ADDITIONAL DIAGNOSTIC ORDERING
discretion of the Radiologist based on indications.  Radiologist may modify this order per protocol to meet the clinical needs of the patient		Provider's Sign  Date:	nature:

CC REPORT TO:

(By checking this box, I acknowledge I have reviewed the standard operating

procedures (SOP) used by Stanislaus Surgical Hospital)