Radiology/Medical Imaging Services Order Sheet

Phone: (360) 379-9235 Fax: (360) 379-2251

Jefferson Healthcare 834 Sheridan Port Townsend, WA 98368

What to Bring

- This Order for Outpatient Services
- Your Health Insurance Card or Medical Coupon

Name:_____D.O.B:_____Date:_____
ICD -10 Code:_____Auth#:_____ Patient Phone: _____
Reason for Exam: (Required) _____ Appt. Date: _____
_____Appt. Time: _____
Phone Results to: _____ Fax Results to: _____
☐ STAT Read ☐ CALL Report ☐ Send CD w/Patient ☐ Mail CD

XRAY

- ☐ Abdomen (KUB)
- ☐ Abdomen (Flat and Upright)
- ☐ Acute Abdomen Series (3-Way)
- ☐ Ankle R L
- ☐ Barium Enema w/air
- ☐ Cervical Spine w/Oblique w/flex, ext
- ☐ Chest PA & Lat 1-View
- ☐ Elbow R L
- ☐ Esophagram w/air
- ☐ Facial Bones
- ☐ Femur R L
- ☐ Finger R L
- ☐ Foot R L
- ☐ Forearm R L
- ☐ Fluoroscopy – Specify _____
- ☐ Hand R L
- ☐ Hip R L
- ☐ Humerus R L
- ☐ Intravenous Pyelogram (IVP)
- ☐ Knee R L
- ☐ Lumbar Spine 3v w/Oblique w/flex, ext
- ☐ Mandible
- ☐ Neck for Soft Tissue
- ☐ Orbits
- ☐ Pelvis
- ☐ Ribs R L w/PA Chest
- ☐ Sacroiliac Joints
- ☐ Sacrum/Coccyx
- ☐ Scoliosis
- ☐ Sinuses
- ☐ Shoulder R L
- ☐ Small Bowel Follow Through (SBFT)
- ☐ Thoracic Spine
- ☐ Tib/Fib R L
- ☐ Toes R L
- ☐ Upper GI w/Esophagus w/air
- ☐ Upper GI w/Small Bowel Follow Through
- ☐ Wrist R L
- ☐ OTHER – Specify_____

CT SCAN

- ☐ Abdomen w/Oral w/IV Creatinine
- ☐ Pelvis w/Oral w/IV Creatinine
- ☐ Chest w/IV Creatinine
- ☐ Chest/Abd/Pelvis w/Oral w/IV Creatinine
- ☐ Enterography w/Oral w/IV Creatinine
- ☐ HR Chest (for ILD)
- ☐ Renal Stone

CT SCAN cont.

Head CT

- ☐ Head w/IV wo/IV Creatinine
- ☐ Facial Bones w/IV wo/IV Creatinine
- ☐ Orbits w/IV wo/IV Creatinine
- ☐ Sinuses
- ☐ Temporal Bones
- ☐ Soft Tissue Neck w/IV wo/IV Creatinine

Spine CT

- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar

Extremity CT

- ☐ Extremity – Specify _____

CT Angiogram

- ☐ Abd/Pel Aorta w/Runoff Creatinine
- ☐ Chest Aorta PE Creatinine
- ☐ Head (COW) Neck (CAR) Creatinine

Muti-Phase CT

- ☐ Liver Creatinine
- ☐ Pancreas Creatinine
- ☐ Renal Creatinine
- ☐ Urogram Creatinine

MAMOGRAM

- ☐ Diagnostic Bilateral R L
- ☐ Screening Bilateral R L

ULTRASOUND

- ☐ Abdomen Complete Limited
- ☐ Aorta
- ☐ Breast Specify Location_____
- ☐ OB
- ☐ Pelvis
- ☐ Renal
- ☐ Scrotum/Testicular
- ☐ Thyroid
- ☐ Other – Specify_____

MRI

Brain MRI

- ☐ Angiogram Head/Neck Creatinine
- ☐ Brain wo w/wo Creatinine
- ☐ Soft Tissue Neck wo w/wo Creatinine
- ☐ Orbits wo w/wo Creatinine
- ☐ Other – Specify_____

Spine MRI

- ☐ Cervical wo w/wo Creatinine
- ☐ Thoracic wo w/wo Creatinine
- ☐ Lumbar wo w/wo Creatinine

Extremity MRI

- ☐ Ankle R L
- ☐ Elbow R L
- ☐ Femur R L
- ☐ Foot R L
- ☐ Hand R L
- ☐ Hip R L Arthrogram
- ☐ Knee R L
- ☐ Shoulder R L Arthrogram
- ☐ Tib/Fib R L
- ☐ Wrist R L Arthrogram
- ☐ Other – Specify_____

Abdomen/Pelvis MRI

- ☐ Abdomen wo w/wo
- ☐ Liver Renal Adrenal
- ☐ Pelvis (bony) w wo
- ☐ Abdomen MRCP Enterography
- ☐ Pelvis Gyn

Bone Density (DXA)

- ☐ Spine & Femur Forearm

Nuclear Medicine

- ☐ Bone – Whole Body
- ☐ Bone Limited Specify_____
- ☐ Bone 3-Phase Specify_____
- ☐ Gastric Emptying
- ☐ Hepatobiliary (HIDA)
- ☐ Lung (VQ)
- ☐ Parathyroid
- ☐ Renogram w/Lasix wo/Lasix
- ☐ Thyroid Uptake & Scan
- ☐ Myocardial Perfusion (Nuclear Stress Test)

Physician Signature:_____DATE:_____TIME:_____

Printed Name: (Required) _____