

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: _____

Phone Results to: _____ Fax Results to: _____ Appt. Time: _____

STAT Read CALL Report Send CD w/Patient Mail CD

<p style="text-align: center;"><u>XRAY</u></p> <p><input type="checkbox"/> Abdomen (KUB)</p> <p><input type="checkbox"/> Abdomen (Flat and Upright)</p> <p><input type="checkbox"/> Acute Abdomen Series (3-Way)</p> <p><input type="checkbox"/> Ankle R L</p> <p><input type="checkbox"/> Barium Enema w/air</p> <p><input type="checkbox"/> Cervical Spine w/Oblique w/flex, ext</p> <p><input type="checkbox"/> Chest PA & Lat 1-View</p> <p><input type="checkbox"/> Elbow R L</p> <p><input type="checkbox"/> Esophagram w/air</p> <p><input type="checkbox"/> Facial Bones</p> <p><input type="checkbox"/> Femur R L</p> <p><input type="checkbox"/> Finger R L</p> <p><input type="checkbox"/> Foot R L</p> <p><input type="checkbox"/> Forearm R L</p> <p><input type="checkbox"/> Fluoroscopy – Specify _____</p> <p><input type="checkbox"/> Hand R L</p> <p><input type="checkbox"/> Hip R L</p> <p><input type="checkbox"/> Humerus R L</p> <p><input type="checkbox"/> Intravenous Pyelogram (IVP)</p> <p><input type="checkbox"/> Knee R L</p> <p><input type="checkbox"/> Lumbar Spine 3v w/Oblique w/flex, ext</p> <p><input type="checkbox"/> Mandible</p> <p><input type="checkbox"/> Neck for Soft Tissue</p> <p><input type="checkbox"/> Orbits</p> <p><input type="checkbox"/> Pelvis</p> <p><input type="checkbox"/> Ribs R L w/PA Chest</p> <p><input type="checkbox"/> Sacroiliac Joints</p> <p><input type="checkbox"/> Sacrum/Coccyx</p> <p><input type="checkbox"/> Scoliosis</p> <p><input type="checkbox"/> Sinuses</p> <p><input type="checkbox"/> Shoulder R L</p> <p><input type="checkbox"/> Small Bowel Follow Through (SBFT)</p> <p><input type="checkbox"/> Thoracic Spine</p> <p><input type="checkbox"/> Tib/Fib R L</p> <p><input type="checkbox"/> Toes R L</p> <p><input type="checkbox"/> Upper GI w/Esophagus w/air</p> <p><input type="checkbox"/> Upper GI w/Small Bowel Follow Through</p> <p><input type="checkbox"/> Wrist R L</p> <p><input type="checkbox"/> OTHER – Specify _____</p> <p style="text-align: center;"><u>CT SCAN</u></p> <p><input type="checkbox"/> Abdomen w/Oral w/IV Creatinine</p> <p><input type="checkbox"/> Pelvis w/Oral w/IV Creatinine</p> <p><input type="checkbox"/> Chest w/IV Creatinine</p> <p><input type="checkbox"/> Chest/Abd/Pelvis w/Oral w/IV Creatinine</p> <p><input type="checkbox"/> Enterography w/Oral w/IV Creatinine</p> <p><input type="checkbox"/> HR Chest (for ILD)</p> <p><input type="checkbox"/> Renal Stone</p>	<p style="text-align: center;"><u>CT SCAN cont.</u></p> <p style="text-align: center;"><u>Head CT</u></p> <p><input type="checkbox"/> Head w/IV wo/IV Creatinine</p> <p><input type="checkbox"/> Facial Bones w/IV wo/IV Creatinine</p> <p><input type="checkbox"/> Orbits w/IV wo/IV Creatinine</p> <p><input type="checkbox"/> Sinuses</p> <p><input type="checkbox"/> Temporal Bones</p> <p><input type="checkbox"/> Soft Tissue Neck w/IV wo/IV Creatinine</p> <p style="text-align: center;"><u>Spine CT</u></p> <p><input type="checkbox"/> Cervical</p> <p><input type="checkbox"/> Thoracic</p> <p><input type="checkbox"/> Lumbar</p> <p style="text-align: center;"><u>Extremity CT</u></p> <p><input type="checkbox"/> Extremity – Specify _____</p> <p style="text-align: center;"><u>CT Angiogram</u></p> <p><input type="checkbox"/> Abd/Pel Aorta w/Runoff Creatinine</p> <p><input type="checkbox"/> Chest Aorta PE Creatinine</p> <p><input type="checkbox"/> Head (COW) Neck (CAR) Creatinine</p> <p style="text-align: center;"><u>Muti-Phase CT</u></p> <p><input type="checkbox"/> Liver Creatinine</p> <p><input type="checkbox"/> Pancreas Creatinine</p> <p><input type="checkbox"/> Renal Creatinine</p> <p><input type="checkbox"/> Urogram Creatinine</p> <p style="text-align: center;"><u>MAMMOGRAM</u></p> <p><input type="checkbox"/> Diagnostic Bilateral R L</p> <p><input type="checkbox"/> Screening Bilateral R L</p> <p style="text-align: center;"><u>ULTRASOUND</u></p> <p><input type="checkbox"/> Abdomen Complete Limited</p> <p><input type="checkbox"/> Aorta</p> <p><input type="checkbox"/> Breast Specify Location _____</p> <p><input type="checkbox"/> OB</p> <p><input type="checkbox"/> Pelvis</p> <p><input type="checkbox"/> Renal</p> <p><input type="checkbox"/> Scrotum/Testicular</p> <p><input type="checkbox"/> Thyroid</p> <p><input type="checkbox"/> Other – Specify _____</p>	<p style="text-align: center;"><u>MRI</u></p> <p style="text-align: center;"><u>Brain MRI</u></p> <p><input type="checkbox"/> Angiogram Head/Neck Creatinine</p> <p><input type="checkbox"/> Brain wo w/wo Creatinine</p> <p><input type="checkbox"/> Soft Tissue Neck wo w/wo Creatinine</p> <p><input type="checkbox"/> Orbits wo w/wo Creatinine</p> <p><input type="checkbox"/> Other – Specify _____</p> <p style="text-align: center;"><u>Spine MRI</u></p> <p><input type="checkbox"/> Cervical wo w/wo Creatinine</p> <p><input type="checkbox"/> Thoracic wo w/wo Creatinine</p> <p><input type="checkbox"/> Lumbar wo w/wo Creatinine</p> <p style="text-align: center;"><u>Extremity MRI</u></p> <p><input type="checkbox"/> Ankle R L</p> <p><input type="checkbox"/> Elbow R L</p> <p><input type="checkbox"/> Femur R L</p> <p><input type="checkbox"/> Foot R L</p> <p><input type="checkbox"/> Hand R L</p> <p><input type="checkbox"/> Hip R L Arthrogram</p> <p><input type="checkbox"/> Knee R L</p> <p><input type="checkbox"/> Shoulder R L Arthrogram</p> <p><input type="checkbox"/> Tib/Fib R L</p> <p><input type="checkbox"/> Wrist R L Arthrogram</p> <p><input type="checkbox"/> Other – Specify _____</p> <p style="text-align: center;"><u>Abdomen/Pelvis MRI</u></p> <p><input type="checkbox"/> Abdomen wo w/wo</p> <p><input type="checkbox"/> Liver Renal Adrenal</p> <p><input type="checkbox"/> Pelvis (bony) w wo</p> <p><input type="checkbox"/> Abdomen MRCP Enterography</p> <p><input type="checkbox"/> Pelvis Gyn</p> <p style="text-align: center;"><u>Bone Density (DXA)</u></p> <p><input type="checkbox"/> Spine & Femur Forearm</p> <p style="text-align: center;"><u>Nuclear Medicine</u></p> <p><input type="checkbox"/> Bone – Whole Body</p> <p><input type="checkbox"/> Bone Limited Specify _____</p> <p><input type="checkbox"/> Bone 3-Phase Specify _____</p> <p><input type="checkbox"/> Gastric Emptying</p> <p><input type="checkbox"/> Hepatobiliary (HIDA)</p> <p><input type="checkbox"/> Lung (VQ)</p> <p><input type="checkbox"/> Parathyroid</p> <p><input type="checkbox"/> Renogram w/Lasix wo/Lasix</p> <p><input type="checkbox"/> Thyroid Uptake & Scan</p> <p><input type="checkbox"/> Myocardial Perfusion (Nuclear Stress Test)</p>
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Physician Signature: _____ DATE: _____ TIME: _____

Printed Name: (Required) _____