

Imaging Order Form Pediatrics



Exam location:

- Building A**
890 Oak St. SE
 Building B
665 Winter St.
 Building C
875 Oak St. SE

LAST NAME: _____ FIRST NAME: _____ MI: _____

Phone: _____ Date of Birth: _____

ICD-9(s) for diagnosis or symptoms: _____

Physician Signature: _____ Date: _____

Printed Name: _____ cc to: _____

Bolded elements are regulated requirements

- Please call patient to schedule exam: *routine* *urgent*
 Patient to walk in for routine x-ray
- Insurance: _____ Member ID Number: _____ Authorization Number: _____
- Prior Related Studies: Y N Location: _____
- Phone results: routine urgent fax/phone to _____ patient to wait _____

General sedation Please provide current history and physical

Examination	Exam Focus								
MRI <input type="checkbox"/> with contrast* <input type="checkbox"/> without contrast *With contrast, diabetic patients must have a Creatinine level within 6 weeks prior to exam. Creatinine _____ Date _____ <input type="checkbox"/> Creatinine on admit	<table border="0"> <tr> <td> <input type="checkbox"/> Cranial <input type="checkbox"/> I.A.C. <input type="checkbox"/> Pituitary <input type="checkbox"/> Other: _____ </td> <td> SPINE <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar </td> <td> EXTREMITY Site: _____ </td> </tr> </table>	<input type="checkbox"/> Cranial <input type="checkbox"/> I.A.C. <input type="checkbox"/> Pituitary <input type="checkbox"/> Other: _____	SPINE <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar	EXTREMITY Site: _____					
<input type="checkbox"/> Cranial <input type="checkbox"/> I.A.C. <input type="checkbox"/> Pituitary <input type="checkbox"/> Other: _____	SPINE <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar	EXTREMITY Site: _____							
CT SCAN <input type="checkbox"/> with contrast* <input type="checkbox"/> without contrast *With contrast, diabetic patients must have a Creatinine level within 6 weeks prior to exam. Creatinine _____ Date _____ <input type="checkbox"/> Creatinine on admit	<table border="0"> <tr> <td> <input type="checkbox"/> Cranial <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Appendix </td> <td> <input type="checkbox"/> Extremity: Site _____ <input type="checkbox"/> Sinuses <input type="checkbox"/> Maxillo-Facial Bones <input type="checkbox"/> Other: _____ <input type="checkbox"/> Special Instructions: _____ </td> </tr> </table>	<input type="checkbox"/> Cranial <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Appendix	<input type="checkbox"/> Extremity: Site _____ <input type="checkbox"/> Sinuses <input type="checkbox"/> Maxillo-Facial Bones <input type="checkbox"/> Other: _____ <input type="checkbox"/> Special Instructions: _____						
<input type="checkbox"/> Cranial <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Appendix	<input type="checkbox"/> Extremity: Site _____ <input type="checkbox"/> Sinuses <input type="checkbox"/> Maxillo-Facial Bones <input type="checkbox"/> Other: _____ <input type="checkbox"/> Special Instructions: _____								
NUCLEAR MEDICINE	<table border="0"> <tr> <td> <input type="checkbox"/> VCU <input type="checkbox"/> Renal <input type="checkbox"/> Type: _____ <input type="checkbox"/> Shunt Patency <input type="checkbox"/> Liver –Gallbladder (HIDA) <input type="checkbox"/> With EF <input type="checkbox"/> Without EF </td> <td> BONE SCAN <input type="checkbox"/> Whole Body <input type="checkbox"/> Limited (Site): _____ <input type="checkbox"/> Other: _____ </td> </tr> </table>	<input type="checkbox"/> VCU <input type="checkbox"/> Renal <input type="checkbox"/> Type: _____ <input type="checkbox"/> Shunt Patency <input type="checkbox"/> Liver –Gallbladder (HIDA) <input type="checkbox"/> With EF <input type="checkbox"/> Without EF	BONE SCAN <input type="checkbox"/> Whole Body <input type="checkbox"/> Limited (Site): _____ <input type="checkbox"/> Other: _____						
<input type="checkbox"/> VCU <input type="checkbox"/> Renal <input type="checkbox"/> Type: _____ <input type="checkbox"/> Shunt Patency <input type="checkbox"/> Liver –Gallbladder (HIDA) <input type="checkbox"/> With EF <input type="checkbox"/> Without EF	BONE SCAN <input type="checkbox"/> Whole Body <input type="checkbox"/> Limited (Site): _____ <input type="checkbox"/> Other: _____								
DIAGNOSTIC RADIOLOGY	<table border="0"> <tr> <td> CHEST/ABDOMEN <input type="checkbox"/> CXR <input type="checkbox"/> 3 V Abdomen <input type="checkbox"/> KUB </td> <td> UROGRAPHY <input type="checkbox"/> I.V.P. <input type="checkbox"/> VCUG <input type="checkbox"/> VCUG w/Sedation </td> <td> SKULL <input type="checkbox"/> 2 View <input type="checkbox"/> 3 View </td> <td> GASTROINTESTINAL <input type="checkbox"/> Esophogram <input type="checkbox"/> Upper GI <input type="checkbox"/> Small Bowel Series <input type="checkbox"/> Lower GI <input type="checkbox"/> Lower GI w/Air </td> </tr> <tr> <td colspan="4"> <input type="checkbox"/> PLAIN FILM X-RAY OF: _____ <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilat </td> </tr> </table>	CHEST/ABDOMEN <input type="checkbox"/> CXR <input type="checkbox"/> 3 V Abdomen <input type="checkbox"/> KUB	UROGRAPHY <input type="checkbox"/> I.V.P. <input type="checkbox"/> VCUG <input type="checkbox"/> VCUG w/Sedation	SKULL <input type="checkbox"/> 2 View <input type="checkbox"/> 3 View	GASTROINTESTINAL <input type="checkbox"/> Esophogram <input type="checkbox"/> Upper GI <input type="checkbox"/> Small Bowel Series <input type="checkbox"/> Lower GI <input type="checkbox"/> Lower GI w/Air	<input type="checkbox"/> PLAIN FILM X-RAY OF: _____ <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilat			
CHEST/ABDOMEN <input type="checkbox"/> CXR <input type="checkbox"/> 3 V Abdomen <input type="checkbox"/> KUB	UROGRAPHY <input type="checkbox"/> I.V.P. <input type="checkbox"/> VCUG <input type="checkbox"/> VCUG w/Sedation	SKULL <input type="checkbox"/> 2 View <input type="checkbox"/> 3 View	GASTROINTESTINAL <input type="checkbox"/> Esophogram <input type="checkbox"/> Upper GI <input type="checkbox"/> Small Bowel Series <input type="checkbox"/> Lower GI <input type="checkbox"/> Lower GI w/Air						
<input type="checkbox"/> PLAIN FILM X-RAY OF: _____ <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilat									
ULTRASOUND	<table border="0"> <tr> <td> <input type="checkbox"/> Abdomen <input type="checkbox"/> Appendix <input type="checkbox"/> Renal <input type="checkbox"/> Pelvic <input type="checkbox"/> Testicular </td> <td> <input type="checkbox"/> Infant Head <input type="checkbox"/> Infant Hips <input type="checkbox"/> Biopsy: Site _____ <input type="checkbox"/> Other: _____ </td> </tr> </table>	<input type="checkbox"/> Abdomen <input type="checkbox"/> Appendix <input type="checkbox"/> Renal <input type="checkbox"/> Pelvic <input type="checkbox"/> Testicular	<input type="checkbox"/> Infant Head <input type="checkbox"/> Infant Hips <input type="checkbox"/> Biopsy: Site _____ <input type="checkbox"/> Other: _____						
<input type="checkbox"/> Abdomen <input type="checkbox"/> Appendix <input type="checkbox"/> Renal <input type="checkbox"/> Pelvic <input type="checkbox"/> Testicular	<input type="checkbox"/> Infant Head <input type="checkbox"/> Infant Hips <input type="checkbox"/> Biopsy: Site _____ <input type="checkbox"/> Other: _____								
CARDIAC NON-INVASIVE SERVICE	<table border="0"> <tr> <td> <input type="checkbox"/> Transthoracic Echocardiogram with Doppler and Color Flow (TTE) <input type="checkbox"/> 12 Lead Electrocardiogram (EKG) Patients may walk in for this exam. Please fax orders to number below. </td> <td> <input type="checkbox"/> Holter Monitor (24 Hour Cardiac Monitor) <input type="checkbox"/> 24 Hour <input type="checkbox"/> 48 Hour <input type="checkbox"/> 72 Hour <input type="checkbox"/> Monitor 30 Day </td> </tr> </table>	<input type="checkbox"/> Transthoracic Echocardiogram with Doppler and Color Flow (TTE) <input type="checkbox"/> 12 Lead Electrocardiogram (EKG) Patients may walk in for this exam. Please fax orders to number below.	<input type="checkbox"/> Holter Monitor (24 Hour Cardiac Monitor) <input type="checkbox"/> 24 Hour <input type="checkbox"/> 48 Hour <input type="checkbox"/> 72 Hour <input type="checkbox"/> Monitor 30 Day						
<input type="checkbox"/> Transthoracic Echocardiogram with Doppler and Color Flow (TTE) <input type="checkbox"/> 12 Lead Electrocardiogram (EKG) Patients may walk in for this exam. Please fax orders to number below.	<input type="checkbox"/> Holter Monitor (24 Hour Cardiac Monitor) <input type="checkbox"/> 24 Hour <input type="checkbox"/> 48 Hour <input type="checkbox"/> 72 Hour <input type="checkbox"/> Monitor 30 Day								

Scheduling: (503) 561-5293
 Fax order form to: (503) 561-4723

Exams with a must be scheduled by the physician's office.

To reorder form, call (503) 561-3778

428526 4/09

Preparations

Please follow carefully to avoid delays in your procedure.

Check applicable	Procedure	Patient Preparations
	General Sedation	Nothing to eat or drink after midnight. You will be contacted by phone by our imaging nursing staff to review instructions prior to the procedure.
	CT	<i>with contrast:</i> Clear Liquids only for 4 hours prior to exam time Drink plenty of water prior to exam May need to have labs drawn prior to procedure Wear loose clothing with no metal if possible Patients may be required to drink Barium commonly used for abdominal studies
	CT	<i>without contrast:</i> No preparation required Wear loose clothing with no metal if possible Patients may be required to drink Barium commonly used for abdominal studies
	MRI	May need to have labs drawn prior to procedure Wear loose clothing with no metal if possible Claustrophobic patients will need to discuss concerns with referring physician
	Ultrasound	<i>Abdominal Ultrasound:</i> Nothing to eat or drink 8 hours prior to exam <i>Pelvis:</i> Consume 20 ounces of water. Finish 30 minutes prior to exam Do not empty bladder prior to exam
	Nuclear Medicine	<i>HIDA:</i> nothing by mouth and no pain medications for 4 hours prior to exam <i>Bone scan:</i> no requirements <i>Thyroid uptake:</i> clear liquids only 4 hours prior to exam, off thyroid meds for 6 weeks, multivitamins for 2 weeks <i>Gastric emptying:</i> nothing by mouth and no smoking or chewing gum 4 hours prior to exam, no reglan 24 hours prior to exam
	Upper GI/ Small Bowel Series	Nothing to eat or drink for 12 hours prior to examination. Infants should have last feeding about 4 hours prior to exam Please note Upper GI may take up to 1 hour; Small Bowel exam may take up to 4 hours
	Barium Enema/IVP	Pick up colonic prep kit as prescribed 3 days prior to exam. <i>No prep for Hirshsprung's Disease or Megacolon.</i>
	Other: _____ _____ _____	

Your exam is scheduled for: **Date:** _____ **Check-in:** _____ **Exam:** _____

Your exam will be located at:

Building A
890 Oak Street SE

Building B
665 Winter Street SE

Building C
875 Oak Street SE