

IMAGING ORDER FORM

Patient Name _____ Phone _____ DOB _____

Diagnosis and Symptoms _____

Scheduled: | Date: _____ Time: _____ Pre-Authorization #: _____

XRAY

- Chest PA and Lateral
- Abdomen (KUB)
- Abdomen (Flat and Upright)
- Ribs _____
- Cervical Spine
- Thoracic Spine
- Lumbar Spine
- Shoulder R or L
- Elbow R or L
- Wrist R or L
- Hand R or L
- Finger _____
- Knee R or L
- Hip R or L
- Pelvis
- Ankle R or L
- Foot R or L
- Orbits (Screening)
- Other _____

ULTRASOUND

- Abdomen Limited/ RUQ
- Abdomen Complete
- Breast R or L Bilat
- Pelvis
- Renal/Bladder
- Aorta
- Carotid
- Thyroid
- Pelvic/Transvaginal
- Testicular
- Upper Extremity Arterial R or L
- Lower Extremity Arterial R or L
- Upper Extremity Venous R or L
- Lower Extremity Venous R or L
- OB-1st Trimester
- Other _____

CT

- Brain (w/o Contrast)
- Brain (w/o & w/ Contrast)
- Abdomen (w/o & w/ IV Contrast)
- Abdomen (w/ IV Contrast)
- Abdomen (w/o IV Contrast)
- Abd/Pelvis (w/o and w/ IV Contrast)
- Abd/Pelvis (w/ IV Contrast)
- Abd/Pelvis (w/o and w/ IV Contrast)
- Sinuses(w/o Contrast)
- Maxillofacial (w/ Contrast)
- Maxillofacial (w/o and w/Contrast)
- Chest (w/o IV contrast)
- Chest (w/ IV contrast)
- Cervical
- Thoracic
- Upper Extremity
- Lower Extremity
- Lumbar
- Soft Tissue Neck
- CTA Abd/Pelvis
- CTA Chest for PE
- Other _____

MRI

- Brain (w/o Contrast)
- Brain (w/o and w/ Contrast)
- Cervical (w/o Contrast)
- Cervical (w/o and w/ Contrast)
- Thoracic (w/o Contrast)
- Thoracic (w & w/o Contrast)
- Lumbar (w/o Contrast)
- Lumbar (w/o and w/ Contrast)
- Hip R L Bilat
- Pelvis
- Knee R or L
- Ankle R or L
- Foot R or L
- Shoulder R or L
- Elbow R or L
- Wrist R or L
- Hand R or L
- Soft Tissue Neck (w/o and w/ Contrast)
- Brachial Plexus
- Abdomen (w/o and w/ Contrast)
- Abdomen (w/o Contrast)
- MRA Intracranial
- MRA Extracranial (w/Contrast)
- Other _____

All patients with history of Renal Disease or Diabetic, must have a Creatinine performed prior to any exams with contrast:

- Within the 45 days prior to all contrasted exam, if normal, or
- Within 10 days prior to contrasted exam if abnormal.

Special Instructions: _____

Ordering Provider (please print): _____ Signature _____

Phone: _____ FAX: _____

PLEASE CALL 260-212-1901 TO SCHEDULE. FAX COMPLETED ORDER TO 260-999-5889 (FRONT ONLY).