KAISER PERMANENTE®

Today's date: ______________________________

REGIONAL RADIOLOGY SERVICES SPECIALTY ORDER FORM

PLEASE NOTE THAT ALL HIGHLIGHTED PORTIONS OF THE FORM ARE NEEDED FOR THE ORDER TO BE COMPLETE

For Radiology Orders:

1. Mark requested study(ies)
2. Sign and date form
3. Fax request to: 303-861-3111
4. Patient calls 303-338-3456 to schedule exams. (Monday through Friday 8:00 A.M 6:00 P.M)

PATIENT NAME (LAST, FIRST):

HEALTH RECORD NO: DOB: GENDER:

PHONE Hm: Wk: Cell:

PERTINENT MEDICAL INFO (e.g. Patient weight, Allergies, Lab, LMP):

ORDERING/REFERRING CLINICIAN (Please print): PHONE/FAX: PAGER:

PROVIDER NPI (UPIN): OFFICE PHONE: PAGER:

EXAM: Routine w/in 2 weeks ASAP 1-2 days STAT Send CDs w/ patient : Y/N

FAX RESULTS TO: CC:

SIGN OR SYMPTOM/DIAGNOSIS: (Please Note: Sign Or Symptom Necessitating The Reason For The Visit Must Be Provided Before Rendering The Service):

ICD-9 Code:

ICD-10 Code:

HEALTH RECORD NO: DOB: GENDER: PHONE Hm: Cell: PERTINENT MEDICAL INFO (e.g. Patient weight, Allergies, Lab, LMP): ORDERING/REFERRING CLINICIAN (Please print): PHONE / FAX: Routine w/in 2 weeks ASAP 1-2 days STAT Send CDs w/ patient Y/N CC: S: (Please Note: Sign Or Symptom Necessitating The Reason For The Visit Must Be Provided Before Rendering The Service):

MAGNETIC RESONANCE (MR)

Exam			
BRAIN	WO	W	WO / W
ORBITS	WO	W	WO / W
CERVICAL SPINE	WO	W	WO / W
THORACIC SPINE	WO	W	WO / W
LUMBAR SPINE	WO	W	WO / W
MRA	WO	W	WO / W
a. Intracranial	WO	W	WO / W
b. Other (specify)	WO	W	WO / W
SOFT TISSUE NECK	WO	W	WO / W
CHEST	WO	W	WO / W
ABDOMEN/LIVER	WO	W	WO / W
PELVIS	WO	W	WO / W
SHOULDER	R	L	B
ELBOW	R	L	B
WRIST	R	L	B
HIP	R	L	B
KNEE	R	L	B
ANKLE	R	L	B
BREAST	R	L	B
IAC	R	L	B
PITUITARY	R	L	B
TMJ	R	L	B
OTHER:			

MAMMOGRAPHY

Exam	
SCREENING	Bil 2 view
DIAGNOSTIC	R
DIAGNOSTIC	L
DIAGNOSTIC	Bil

FLUOROSCOPY

- ESOPHAGRAM
- UPPER GI
- SMALL BOWEL FOLLOW THROUGH
- BARIUM ENEMA
- HYSTEROSALPINGOGRAM
- VCUG (XRay)
- JOINT INJECTION:

NUCLEAR MEDICINE

- THYROID SCAN
- I 131 THYROID WHOLE BODY
- I 131 THYROID THERAPY
- BONE SCANS
  - a. Routine - Whole Body
  - b. Triple Phase (with Flow Study)
  - c. With Spect
- MUGA SCAN
- HIDA SCAN
- HIDA SCAN with EF
- GASTRIC EMPTYING SCAN
- LUNG SCAN - VENT & PERF
- MYOCARDIAL PERFUSION
- LIVER / SPLEEN HEMANGIOMA
- OCTREOTIDE INDIUM WHOLE BODY SCAN
- OTHER

BMD

- BONE MINERAL DENSITOMETRY

ULTRASOUND

Exam			
ABDOMEN LIMITED RUQ/LUQ			
ABDOMEN COMPLETE/Limited			
RENAL			
AORTA			
VENOUS DOPPLER	R	L	B
PELVIS TRANSVAGINAL			
OB			
CAROTID			
THYROID			
SCROTAL			
BREAST	R	L	B
OTHER:			

CT SCAN

Exam			
BRAIN	WO	W	WO / W
FACIAL BONES			
CHEST	WO	W	WO / W
ABDOMEN	WO	W	WO / W
PELVIS	WO	W	WO / W
HIP			
CERVICAL SPINE			
THORACIC SPINE (level):			
LUMBAR SPINE			
CT ARTHOGRAPHY			
EXTREMITY (specify):			
CT MYELOGRAPHY (specify):			
OTHER			

CERVICAL SPINE level: THORACIC SPINE (level): LUMBAR SPINE CHEST WO W WO/W ABDOMEN WO W WO/W PELVIS WO W WO/W HIP CT ARTHOGRAPHY FACIAL BONES EXTREMTY (specify): OTHER:

ORDERING CLINICIAN'S SIGNATURE **Required:** ➡

DATE: