

Radiology Services Order

PATIENT INFORMATION Today's Date:		To Schedule an Appointment:	
Patient's Name:		1. Fax Form to: 513-803-1111 or 1-866-877-8905	
DOB:		2. To Schedule a Routine Imaging Appointment, Call 513-636-4251, option #1	
Gender:		Note: X-rays do not require a scheduled appointment	
Mother's Name:		3. To Schedule a STAT Imaging Appointment, Call 513-636-4251, option #2	
Phone:		Order Priority: <input type="checkbox"/> Routine <input type="checkbox"/> STAT	
Alternate Phone:		Pre-Authorization # (if available):	

SYMPTOMS AND REASON FOR REQUEST (REQUIRED)

Symptoms, background information, or clinical history:

Reason for request, potential ICD diagnosis, or specific question(s) to be answered:

X-RAY		ULTRASOUND
CORE/TRUNK	LOWER EXTREMITY	BODY PART(S)
<input type="checkbox"/> ABDOMEN	<input type="checkbox"/> FEMUR <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> ABDOMEN (upper)
<input type="checkbox"/> CHEST	<input type="checkbox"/> KNEE <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> SINGLE QUADRANT
<input type="checkbox"/> CHEST / ABD (FOREIGN BODY)	<input type="checkbox"/> TIBIA / FIBULA <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> RENAL
<input type="checkbox"/> RIBS <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> ANKLE <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> PELVIS (Gyn)
<input type="checkbox"/> STERNUM	<input type="checkbox"/> FOOT <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> EXTREMITY (Specify): <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B
<input type="checkbox"/> HIP <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> TOE (SPECIFY DIGIT): <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	OTHER:
SPECIFY VIEWS (IF APPLICABLE):	SPECIFY VIEWS (IF APPLICABLE):	
HEAD	OTHER	CT SCANS*
<input type="checkbox"/> SINUS (WATERS ONLY)	<input type="checkbox"/> SOFT TISSUE NECK (AIRWAYS):	<input type="checkbox"/> BODY PART(S):
<input type="checkbox"/> SINUS SERIES	<input type="checkbox"/> NASO LATERAL (ADENOIDS)	IF EXTREMITY: <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B
<input type="checkbox"/> SKULL	<input type="checkbox"/> BONE AGE	SPECIFIC INSTRUCTIONS:
<input type="checkbox"/> NASAL BONES	<input type="checkbox"/> OTHER:	
<input type="checkbox"/> FACIAL BONES	UPPER EXTREMITY	
<input type="checkbox"/> ORBITS	<input type="checkbox"/> SHOULDER <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	MRI*
<input type="checkbox"/> MANDIBLE <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> CLAVICLE <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> BODY PART(S):
SPECIFY VIEWS (IF APPLICABLE):	<input type="checkbox"/> HUMERUS <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	IF EXTREMITY: <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B
SPINE	<input type="checkbox"/> ELBOW <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	SPECIFIC INSTRUCTIONS:
<input type="checkbox"/> C-SPINE	<input type="checkbox"/> RADIUS / ULNA <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	
<input type="checkbox"/> T-SPINE	<input type="checkbox"/> WRIST <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	
<input type="checkbox"/> L-SPINE	<input type="checkbox"/> SCAPHOID SERIES <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	
<input type="checkbox"/> SACRUM / COCCYX	<input type="checkbox"/> HAND <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	
<input type="checkbox"/> SCOLIOSIS	<input type="checkbox"/> FINGER(SPECIFY DIGIT): <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	
SPECIFY VIEWS (IF APPLICABLE):	SPECIFY VIEWS (IF APPLICABLE):	
FLUOROSCOPY		NUCLEAR MEDICINE*
<input type="checkbox"/> CONTRAST ENEMA	<input type="checkbox"/> UPPER GI	<input type="checkbox"/> BODY PART(S) / EXAM(S):
<input type="checkbox"/> ESOPHAGRAM	<input type="checkbox"/> VOIDING CYSTO (VCUG)	
<input type="checkbox"/> IVP	<input type="checkbox"/> FEEDING TUBE	
<input type="checkbox"/> SMALL BOWEL	<input type="checkbox"/> OTHER:	
SPECIFIC INSTRUCTIONS:		

The Radiology & Anesthesiology departments will triage the patient to determine if the patient should be scheduled awake vs sedation vs anesthesia

REQUESTING PRACTITIONER GROUP		
Practice Name:	Office Address:	
Telephone:	Date:	Time:
Signature/Credentials of Ordering Practitioner:		
Print Name of Ordering Practitioner:		