

STAT

Summit Medical Center Diagnostic Imaging Order Form

Scheduling (307) 232-4070 Fax: (307) 232-4071

Call or Fax Results: # _____

Patient Information

Name: _____	Birthdate: _____
Address: _____	Phone: _____
Insurance: _____	2 nd Ins: _____
Insurance ID: _____	ID: _____
Group #: _____	Group#: _____

REQUIRED

Signs and Symptoms:

ICD-10 Codes: _____	ORDERING PHYSICIAN: _____
Physician's Signature: _____	Date: _____

X-RAY

<input type="checkbox"/> Chest <input type="radio"/> 1V or <input type="radio"/> 2V	<input type="checkbox"/> AC Joints	<input type="checkbox"/> Sacrum/Coccyx	<input type="checkbox"/> <input type="radio"/> Sinus <input type="radio"/> Facial Bones <input type="radio"/> Nasal
<input type="checkbox"/> Ribs	<input type="checkbox"/> C-Spine <input type="radio"/> 2V-3V <input type="radio"/> 4V-5V <input type="radio"/> Flex/Ext	<input type="checkbox"/> Upper Extremity <input type="radio"/> RT or <input type="radio"/> LT	<input type="checkbox"/> <input type="radio"/> Skull <input type="radio"/> Orbits <input type="radio"/> Eyes, Foreign Body MRI Screening
<input type="checkbox"/> Abdomen <input type="radio"/> 1V KUB or <input type="radio"/> 2V	<input type="checkbox"/> T-Spine <input type="radio"/> 2V <input type="radio"/> 3V <input type="radio"/> 4V	Specify _____	<input type="checkbox"/> Skeletal Survey
<input type="checkbox"/> Acute Abdominal Series 3V (incl. CXR)	<input type="checkbox"/> L-Spine <input type="radio"/> 2V-3V <input type="radio"/> 4V-5V <input type="radio"/> Flex/Ext	<input type="checkbox"/> Lower Extremity <input type="radio"/> RT or <input type="radio"/> LT	<input type="checkbox"/> Bone Age
<input type="checkbox"/> Soft Tissue Neck	<input type="checkbox"/> Pelvis	Specify _____	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> Clavicle <input type="radio"/> RT or <input type="radio"/> LT	<input type="checkbox"/> Hip <input type="radio"/> RT or <input type="radio"/> LT	*No SCOLIOSIS Series*	

MAMMOGRAPHY/BREAST

<input type="checkbox"/> Screening Mammo. <u>IMPLANTS</u> <input type="radio"/> Y or <input type="radio"/> N	<input type="checkbox"/> Diagnostic Mammo <input type="radio"/> RT <input type="radio"/> LT OR <input type="radio"/> Bilat <u>IMPLANTS</u> <input type="radio"/> Y or <input type="radio"/> N
	<input type="checkbox"/> Breast US <input type="radio"/> RT <input type="radio"/> LT OR <input type="radio"/> Bilat <u>IMPLANTS</u> <input type="radio"/> Y or <input type="radio"/> N

ULTRASOUND

<input type="checkbox"/> Abdomen complete	<input type="checkbox"/> Aorta	<input type="checkbox"/> Testicular	<input type="checkbox"/> OB <input type="radio"/> <14 weeks <input type="radio"/> >14 weeks <input type="radio"/> Complete <input type="radio"/> O(w/Add'l Gest)
<input type="checkbox"/> Abdomen limited	<input type="checkbox"/> Hernia <input type="radio"/> RT or <input type="radio"/> LT	<input type="checkbox"/> Venous Doppler for DVT	<input type="radio"/> Limited <input type="radio"/> Transvaginal <input type="radio"/> F/U <input type="radio"/> Biophysical Profile
Specify Organ: _____	<input type="checkbox"/> Neck, Thyroid	<input type="checkbox"/> Lower Ext <input type="radio"/> RT or <input type="radio"/> LT	<input type="checkbox"/> Complete Pelvic (transvaginal & transabdominal)
<input type="checkbox"/> GB <input type="radio"/> W/CCK	<input type="checkbox"/> Carotid	<input type="checkbox"/> Upper Ext <input type="radio"/> RT or <input type="radio"/> LT	<input type="checkbox"/> Palpable Lump -Specify Site: _____
<input type="checkbox"/> Renal <input type="radio"/> Routine <input type="radio"/> W/Pre and Post Void	<input type="checkbox"/> Extremity Non-Vascular		<input type="checkbox"/> OTHER _____

CT

<input type="checkbox"/> Perform BUN & Creatinine	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Head	<input type="checkbox"/> Extremity Upper <input type="radio"/> RT or <input type="radio"/> LT	<input type="checkbox"/> C-Spine
<input type="checkbox"/> BUN & Creatinine performed within 30 days. Will send labs	<input type="checkbox"/> Abdomen & Pelvis	<input type="checkbox"/> Sinus <input type="radio"/> Routine or <input type="radio"/> Stealth	Specify Part _____	<input type="checkbox"/> T-Spine
<input type="checkbox"/> WO IV Contrast	<input type="checkbox"/> Stone Protocol (Abd/Pelvis No Contrast)	<input type="checkbox"/> Facial Bones	<input type="checkbox"/> Extremity Lower <input type="radio"/> RT or <input type="radio"/> LT	<input type="checkbox"/> L-Spine
<input type="checkbox"/> W IV Contrast	<input type="checkbox"/> Chest (no cardiac)	<input type="checkbox"/> Orbits	Specify Part _____	<input type="checkbox"/> CT Angiography
<input type="checkbox"/> WO/W IV Contrast	<input type="checkbox"/> Low Dose Lung Screening	<input type="checkbox"/> Mandible	<input type="checkbox"/> CONFORMIS Knee <input type="radio"/> RT or <input type="radio"/> LT	Specify Exam: _____
<input type="checkbox"/> Oral Contrast (Abd. and/or pelvis only)	<input type="checkbox"/> Pelvis <input type="radio"/> Mass or <input type="radio"/> Bony	<input type="checkbox"/> Soft Tissue Neck		<input type="checkbox"/> OTHER _____

MRI

<input type="checkbox"/> Perform BUN & Creatinine	<input type="checkbox"/> Brain	<input type="checkbox"/> Soft Tissue Neck	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Extremity Upper <input type="radio"/> RT or <input type="radio"/> LT
<input type="checkbox"/> BUN & Creatinine performed within 30 days. Will send labs.	<input type="checkbox"/> Pituitary	<input type="checkbox"/> MRA	<input type="checkbox"/> MRCP	<input type="checkbox"/> Pelvis Sports Hernia	Specify Part: _____
<input type="checkbox"/> WO IV Contrast	<input type="checkbox"/> IAC	Specify: _____	<input type="checkbox"/> C-Spine	<input type="checkbox"/> Female Pelvis	<input type="checkbox"/> Extremity Lower <input type="radio"/> RT or <input type="radio"/> LT
<input type="checkbox"/> WO/W IV Contrast	<input type="checkbox"/> Orbits	<input type="checkbox"/> MRV	<input type="checkbox"/> T-Spine	Specify: _____	Specify Part: _____
	Specify: _____	<input type="checkbox"/> L-Spine	<input type="checkbox"/> Sacrum		<input type="checkbox"/> OTHER _____



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