☐ **STAT**

☐Call or ☐Fax Results: #

Summit Medical Center Diagnostic Imaging Order Form

Scheduling (307) 232-4070 Fax: (307) 215-0753

Patient Information

Name: _____ Birthdate: _____

Address: _____ Phone: _____

Insurance:	2nd Ins:
Insurance ID:	ID:
Group #:	Group#:

REQUIRED

Signs and Symptoms: _____

ICD-10 Codes: _____ **ORDERING PHYSICIAN:** _____

Physician's Signature: _____ **Date:** _____

X-RAY

☐ Chest **O** 1V or **O** 2V
☐ Ribs
☐ Abdomen **O** 1V KUB or **O** 2V
☐ Acute Abdominal Series 3V (incl. CXR)
☐ Soft Tissue Neck
☐ Clavicle **O** RT or **O** LT

☐ AC Joints
☐ C-Spine **O** 2V-3V **O** 4V-5V **O** Flex/Ext
☐ T-Spine **O** 2V **O** 3V **O** 4V
☐ L-Spine **O** 2V-3V **O** 4V-5V **O** Flex/Ext
☐ Pelvis
☐ Hip **O** RT or **O** LT

☐ Sacrum/Coccyx
☐ Upper Extremity **O** RT or **O** LT
Specify_____
☐ Lower Extremity **O** RT or **O** LT
Specify_____

☐ **O** Sinus **O** Facial Bones **O** Nasal
O Skull **O** Orbits
☐ Skeletal Survey
☐ Bone Age
☐ OTHER_____
No SCOLIOSIS Series

MAMMOGRAPHY/BREAST

☐ Screening Mammo IMPLANTS ○ Y or ○ N

☐ Diagnostic Mammo **O** RT **O** LT OR **O** Bilat (ORDER BILAT IF NO PRIOR MAMMO w/in 1 YEAR)
☐ **Breast US** **O** RT **O** LT OR **O** Bilat
☐ **Breast US If Indicated** **O** RT **O** LT OR **O** Bilat

ULTRASOUND

☐ Abdomen complete
☐ Abdomen limited
Specify Organ:_____
☐ GB **O W/CCK**
☐ Renal ○ Routine ○ W/Pre and Post Void
☐ OTHER_____

☐ Aorta
☐ Hernia **O** RT or **O** LT
☐ Neck, Thyroid
☐ Carotid
☐ Extremity Non-Vascular

☐ Testicular
☐ Venous Doppler for DVT
Lower Ext **O** RT or **O** LT
Upper Ext **O** RT or **O** LT

☐ OB
O Less than 14 weeks O Greater than14 weeks O Complete
O (w/Add'l Gest) O Limited O Transvaginal O Follow up
O Biophysical Profile O Umbilical Artery Doppler
☐ Complete Pelvic (transvaginal & transabdominal)
☐ Palpable Lump -Specify Site:_____

CT

☒ Perform BUN & Creatinine if meets criteria.
☐ BUN & Creatinine performed within 30 days. Will send labs
O WO IV Contrast
O W IV Contrast
O WO/W IV Contrast
O Oral Contrast (Abd. and/or pelvis only)

☐ Abdomen
☐ Abdomen & Pelvis
☐ Stone Protocol (Abd/Pelvis No Contrast)
☐ Chest (no cardiac)
O Routine O PE O Nodule
☐ Low Dose Lung Screening

☐ Head
☐ Sinus **O Routine or O Stealth**
☐ Facial Bones
☐ Orbits
☐ Mandible
☐ Soft Tissue Neck
☐ Pelvis **O Mass or O Bony**

☐ Extremity Upper **O** RT or **O** LT
Specify Part_____
☐ Extremity Lower **O** RT or **O** LT
Specify Part_____
☐ CONFORMIS Knee
O RT or **O** LT

☐ C-Spine
☐ T-Spine
☐ L-Spine
☐ CT Angiography
Specify Exam:_____
☐ OTHER_____

MRI

☒ **IF Meets Criteria, please perform X-RAY ORBITS, Foreign Body for MRI Screening**

☒ Perform BUN & Creatinine if meets criteria
☐ BUN & Creatinine performed within 30 days. Will send labs.
O WO IV Contrast
O WO/W IV Contrast
O Arthrogram

☐ Brain
☐ Pituitary
☐ IAC
☐ Orbits

☐ Soft Tissue Neck
☐ MRA
Specify:_____
☐ MRV
Specify:_____

☐ Abdomen
☐ MRCP
☐ C-Spine
☐ T-Spine
☐ L-Spine

☐ Pelvis
☐ Pelvis Sports Hernia
☐ Female Pelvis
Specify:_____
☐ Sacrum

☐ Extremity Upper **O** RT or **O** LT
Specify Part:_____
☐ Extremity Lower **O** RT or **O** LT
Specify Part:_____
☐ OTHER_____

SUMMIT MEDICAL CENTER
Elevating the Standards of HealthCare.

Summit Medical Center
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