

# Outpatient Radiology Order Form

Please complete all fields.

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Appt. Date/Time \_\_\_\_\_

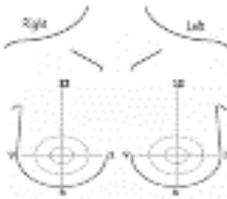
Clinical Information/Symptoms \_\_\_\_\_

Diagnosis Code(s) \_\_\_\_\_ CPT Code (if applicable): \_\_\_\_\_

## Decision Support/AUC information\*

Score\* \_\_\_\_\_ Vendor\* \_\_\_\_\_ If not available, provide Exception Code\* \_\_\_\_\_

To connect with Stanson (AUC) website: <https://portal.stansonhealth.com/register/portal?code=ECUHealth>

<h3>Radiographic Exam</h3> <ul style="list-style-type: none"><li><input type="checkbox"/> 2 view chest PA/lateral</li><li><input type="checkbox"/> Single view chest</li><li><input type="checkbox"/> Abdomen KUB - 1 view</li><li><input type="checkbox"/> Abdomen 2 view</li><li><input type="checkbox"/> Abdomen acute series</li><li><input type="checkbox"/> Spine: <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Complete <input type="checkbox"/> AP/lateral only <input type="checkbox"/> Flex/extension</li><li><input type="checkbox"/> Scoliosis <input type="checkbox"/> Pelvis</li><li><input type="checkbox"/> Hip with 1 view: <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilateral</li><li><input type="checkbox"/> Ribs with 1 chest view <input type="checkbox"/> Orbits</li><li><input type="checkbox"/> Neck soft tissue <input type="checkbox"/> Bone age</li><li><input type="checkbox"/> Joints and extremities <input type="checkbox"/> R: _____ <input type="checkbox"/> L: _____</li><li><input type="checkbox"/> Weight bearing</li><li><input type="checkbox"/> Fluoroscopy: _____</li></ul>	<h3>PET continued</h3> <p>Indication for PET tumor scan:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Diagnosis <input type="checkbox"/> Initial treatment</li><li><input type="checkbox"/> Subsequent treatment</li><li><input type="checkbox"/> Brain: <input type="checkbox"/> Seizure <input type="checkbox"/> Necrosis</li></ul> <h3>Ultrasound</h3> <ul style="list-style-type: none"><li><input type="checkbox"/> Abdomen complete (liver, GB, pancreas, kidneys)</li><li><input type="checkbox"/> Abdomen limited (RUQ-GB, liver, pancreas)</li><li><input type="checkbox"/> Pelvis transvaginal/transabd. (uterus/ovaries)</li><li><input type="checkbox"/> Pelvis (general)</li><li><input type="checkbox"/> Aorta</li><li><input type="checkbox"/> Renal (kidneys, bladder)</li><li><input type="checkbox"/> Renal transplant</li><li><input type="checkbox"/> Renal doppler</li><li><input type="checkbox"/> Carotid doppler</li><li><input type="checkbox"/> Obstetrical</li><li><input type="checkbox"/> Testicular/scrotum</li><li><input type="checkbox"/> Extremity</li><li><input type="checkbox"/> Venous doppler: <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilateral <input type="checkbox"/> Lower extremity <input type="checkbox"/> Upper extremity</li><li><input type="checkbox"/> Venous insufficiency</li><li><input type="checkbox"/> Soft tissue other than head/neck: Specify _____</li><li><input type="checkbox"/> Thyroid</li><li><input type="checkbox"/> TIPS evaluation</li><li><input type="checkbox"/> Other: Specify _____</li></ul> <h3>CT Scan</h3> <p>Designate: _____</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Without contrast <input type="checkbox"/> With contrast</li><li><input type="checkbox"/> 3D reconstruction</li></ul> <h3>Neuro:</h3> <ul style="list-style-type: none"><li><input type="checkbox"/> Head/brain <input type="checkbox"/> Facial bones</li><li><input type="checkbox"/> Orbits <input type="checkbox"/> Temporal bones</li><li><input type="checkbox"/> Sinuses <input type="checkbox"/> Brain lab</li><li><input type="checkbox"/> Soft tissue neck</li></ul>	<h3>CT Scan continued</h3> <h4>Neuro continued:</h4> <ul style="list-style-type: none"><li><input type="checkbox"/> Spine: <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar</li><li><input type="checkbox"/> CTA head (COW) <input type="checkbox"/> CTA neck (carotids)</li><li><input type="checkbox"/> Craniocytosis</li></ul> <h4>Body:</h4> <ul style="list-style-type: none"><li><input type="checkbox"/> Chest <input type="checkbox"/> CTA chest (PE/Aorta)</li><li><input type="checkbox"/> Low dose chest for cancer screening</li><li><input type="checkbox"/> High resolution chest</li><li><input type="checkbox"/> Calcium scoring</li><li><input type="checkbox"/> Cardiac (heart) <input type="checkbox"/> TAVR protocol</li><li><input type="checkbox"/> Watchman/Cardiac vein mapping</li><li><input type="checkbox"/> Abdomen/pelvis</li><li><input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis</li><li><input type="checkbox"/> Renal stone protocol Allow IV contrast if needed</li><li><input type="checkbox"/> Enterography</li><li><input type="checkbox"/> CT virtual colonography</li><li><input type="checkbox"/> CTA abdomen/pelvis</li><li><input type="checkbox"/> CTA abdomen (liver/pancreas/renal/aorta)</li><li><input type="checkbox"/> Extremity: <input type="checkbox"/> R <input type="checkbox"/> L Specify _____</li><li><input type="checkbox"/> CTA aorta-iliac femoral runoff</li></ul> <h3>Mammography</h3> <ul style="list-style-type: none"><li><input type="checkbox"/> Screening <input type="checkbox"/> Diagnostic</li><li><input type="checkbox"/> Breast ultrasound</li><li><input type="checkbox"/> Core biopsy/aspiration (if indicated by radiologist)</li><li><input type="checkbox"/> Bone density DEXA</li><li><input type="checkbox"/> Breast TAG placement</li><li><input type="checkbox"/> Breast wire localization</li></ul> 
<h3>Nuclear Medicine</h3> <ul style="list-style-type: none"><li><input type="checkbox"/> Bone, total body <input type="checkbox"/> Bone, three phase</li><li><input type="checkbox"/> Indium white blood cell</li><li><input type="checkbox"/> Thyroid uptake/scan</li><li><input type="checkbox"/> Total body iodine</li><li><input type="checkbox"/> Thyroid therapy ablation <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Cancer</li><li><input type="checkbox"/> Parathyroid/sestamibi</li><li><input type="checkbox"/> Liver/spleen</li><li><input type="checkbox"/> Renal: <input type="checkbox"/> w/ Lasik <input type="checkbox"/> w/o Lasik</li><li><input type="checkbox"/> GI: <input type="checkbox"/> Emptying <input type="checkbox"/> Meckles</li><li><input type="checkbox"/> Hepatobiliary (HIDA): <input type="checkbox"/> w/ CCK <input type="checkbox"/> w/o CCK <input type="checkbox"/> Leak</li><li><input type="checkbox"/> Lung/VQ: <input type="checkbox"/> PE <input type="checkbox"/> Differential</li><li><input type="checkbox"/> Cardiac: <input type="checkbox"/> Stress test <input type="checkbox"/> MUGA <input type="checkbox"/> Infarct</li></ul>		
<h3>PET</h3> <ul style="list-style-type: none"><li><input type="checkbox"/> Body PET (tumor)</li></ul> <p>Identify primary cancer: _____</p>		
<h3>Other</h3> <ul style="list-style-type: none"><li><input type="checkbox"/> Other procedure not listed: _____</li></ul>		

Comments: \_\_\_\_\_

Provider signature: \_\_\_\_\_ Provider name: \_\_\_\_\_

Supervising MD (if applicable): \_\_\_\_\_

**For all procedures, please complete the following:**

Patient weight: \_\_\_\_\_

Authorization # (primary insurance): \_\_\_\_\_ Authorization date: \_\_\_\_\_

Authorization # (secondary insurance): \_\_\_\_\_ Authorization date: \_\_\_\_\_

Does the patient need sedation or anesthesia for this procedure?  Yes  No

## For females 12-55

Is the patient post-menopausal, had a hysterectomy, tubal ligation or partner has had a vasectomy?

YES  NO

Is there a chance of pregnancy?  YES  NO

If yes, date of LMP: \_\_\_\_\_

## Contrast studies for CT/MRI/VIR and some X-ray exams

Does the patient have a contrast allergy?  YES  NO

## CT

Is the patient 60 years old or older or have diabetes or renal impairment?  YES  NO

*If yes, a creatinine level must be drawn within 7 days of the scheduled procedure.*

Does the patient have a contrast allergy?  YES  NO

*If yes, patient needs to be pre-medicated per Radiology Protocol.*

Does the patient have life-long asthma?  YES  NO Does the patient have a port?  YES  NO

*If yes, follow patient pre-medication prep policy.*

## Mammogram

Does the patient have pain, tenderness, lumps?  YES  NO Date of last mammogram: \_\_\_\_\_

Does the patient have breast implants?  YES  NO Interpreting practice?  ERI  CBIS

Okay to proceed with additional imaging as needed?  YES  NO

## Nuclear Medicine/PET

Is the patient currently breast-feeding?  YES  NO Date of last sexual activity: \_\_\_\_\_

Is there suspected lower extremity involvement?  YES  NO

Is there suspected head extremity involvement?  YES  NO

Is there suspected liver involvement?  YES  NO

Is the patient diabetic?  YES  NO Do they have an insulin pump?  YES  NO

Is this a new cancer?  YES  NO Is this for treatment planning?  YES  NO

*Please Note: additional information may need to be collected prior to scheduling*