Nemours. Children's Hospital

PATIENT NAME: ______________________________________

DOB OR MRN: ______________________________

Medical Imaging Order Form

DATE: ______________________________________

LOCATION:___________________________________

PLEASE NOTE: SCHEDULED SERVICES ARE OFFERED AT NCH ONLY. ALL SCHEDULED PROCEDURES REQUIRE AUTHORIZATION PRIOR TO SCHEDULING APPOINTMENT

THIS FORM MUST BE FAXED TO (407) 567-5903 AND PROVIDED TO THE PARENT TO BE PRESENTED AT THE TIME OF PROCEDURE

	X-RAY (Walk-In Services)		X-RAY (Walk-In Services)		ULTRASOUND (Scheduled Service)
	CORE/TRUNK		**LOWER EXTREMITY**		**BODY PART(S)**
	ABDDOMEN		FEMUR ☐ R ☐ L		
	CHEST		KNEE ☐ R ☐ L		FOR ABDOMINAL: ☐ UPPER ☐ LOWER
	CHEST/ABDOMEN		TIB/FIBULA ☐ R ☐ L		IF EXTREMITY: ☐ R ☐ L
	RIBS ☐ R ☐ L		ANKLE ☐ R ☐ L		
	SHOULDER ☐ R ☐ L		FOOT ☐ R ☐ L		SPECIFIC INSTRUCTIONS :
	STERNUM		TOE (SPECIFY DIGIT) ☐ R ☐ L		
	HIP ☐ R ☐ L		SPECIFY VIEWS (IF APPLICABLE):		
	SPECIFY VIEWS (IF APPLICABLE):				**COMPUTED TOMOGRAPHY (CT) (Scheduled Service)**
			OTHER		**BODY PART(S)**
	HEAD		SOFT TISSUE NECK (AIRWAYS)		
	SINUS (WATERS VIEW ONLY)		NASOPHARYNX LATERAL (ADENOIDS)		IF EXTREMITY: ☐ R ☐ L
	SINUS SERIES		BONE AGE		
	SKULL		OTHER:		SPECIFIC INSTRUCTIONS :
	NASAL BONES				
	FACIAL BONES		**CARDIOLOGY (Walk-In Service)**		
	ORBITS				**MAGNETIC RESONANCE IMAGING (MRI) (Scheduled Service)**
	SPECIFY VIEWS (IF APPLICABLE):		**ELECTROCARDIOGRAM (ECG)**		
			SPECIFIC INSTRUCTIONS:		**BODY PART(S)**
	SPINE		**NUCLEAR MEDICINE (Scheduled Service)**		IF EXTREMITY: ☐ R ☐ L
	CERVICAL-SPINE				
	THORACIC-SPINE		BONE SCAN		SPECIFIC INSTRUCTIONS :
	LUMBAR-SPINE		HIDA (HEPATOBRLIARY) SCAN WITH CHOLECYSTOKININ (CCK)		
	SACRUM/COCCYX		HIDA (HEPATOBRLIARY) SCAN WITHOUT CHOLECYSTOKININ (CCK)		
	SCOLIOSIS		LUNG PERFUSION		**FLUOROSCOPY (Scheduled Service)**
	SPECIFY VIEWS (IF APPLICABLE):		MECKELS DIVERTICULUM		
			GASTROINTESTINAL (GI) BLEED		BARIUM ENEMA (BE)
			GFR (GLOMERULAR FILTRATION RATE) RENAL		BARIUM ENEMA (BE) WITH AIR CONTRAST
	UPPER EXTREMITY		GASTRIC EMPTY - SOLID		MODIFIED BARIUM SWALLOW
	HUMERUS ☐ R ☐ L		GASTRIC EMPTY - LIQUID		UPPER GI
	ELBOW ☐ R ☐ L		MAG3 RENAL WITH LASIX (MERCAPTOACETYLTRIGLYCINE)		SMALL BOWEL SERIES
	RADIUS/ULNA ☐ R ☐ L		DMSA (DIMERCAPTOSUCCINIC ACID) RENAL		VCUG VOIDING CYSTOURETHROGRAM
	WRIST ☐ R ☐ L		SALIVAGRAM		CHECK TUBE PLACEMENT
	SCAPHOID SERIES ☐ R ☐ L				
	HAND ☐ R ☐ L				OTHER:
	FINGER (SPECIFY DIGIT) ☐ R ☐ L				
	SPECIFY VIEWS (IF APPLICABLE):				SPECIFIC INSTRUCTIONS :

LEGEND ☐ R = RIGHT ☐ L = LEFT

REASON FOR EXAM/SPECIAL INSTRUCTIONS

What is the patient history?____

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When did the symptoms start?____

Where is the primary focus of the pain/injury? ______________________________ INTERNATIONAL CLASSIFICATION OF DISEASES (ICD) CODE: ______________

Special Instructions/Additional Information ____

Office Name ______________________________________ Practitioner Name ____

Office Address ___________________________ Telephone __________________________________ Fax_____________________

Signature / Credentials of ordering Practitioner ______________________________________ Date _____________ Time _____________

Print Name (if different from provider above)____