McLaren BAY REGION

DOING WHAT'S BEST.

OUTPATIENT RADIOLOGY ORDER FORM

Appointment Date: _____

Appointment Time: _____

McLaren Bay Region Central Scheduling• Ph:1-800-McLaren • Fax:989-894-6143

PATIENT INFORMATION

Patient Name:_____ DOB: _____

Height:_____ Weight:_____ Patient Phone: _____

INSURANCE_____ PRE-AUTHORIZATION NUMBER:_____

DIAGNOSIS / REASON FOR EXAM(PLEASE INCLUDE LATERALITY; SPECIFIC SITE: _____

ORDERING PROVIDER (PRINT NAME):_____ OFFICE CONTACT: _____

MAMM

- ☐ SCREENING
- ☐ BONE DENSITY
- ☐ DIAGNOSTIC
  - ☐ UNILATERAL
  - ☐ BILATERAL
  - ☐ LT ☐ RT

PET

- ☐ **INITIAL STAGING**
- ☐ **SUBSEQUENT**
- ☐ SKULL TO MID-THIGH
- ☐ WHOLE BODY (MELANOMA)
- ☐ MYOCARDIAL VIABILITY
- ☐ BRAIN – ALZHEIMERS/DEMENTIA
- ☐ NAF BONE SCAN
- ☐ GALLIUM GA 68-DOTATATE

X-RAY

X-RAY _____

FLUOROSCOPY ☐ BARIUM SWALLOW ☐ UGI ☐ SB ☐ BE *See back of order for Prep*

☐ VIDEO ESOPH ☐ IVP ☐ VCUG ☐ CYSTOGRAM

US

- ☐ PELVIC (WITH TRANS VAG IF NECESSARY) ☐ ABDOMEN ☐ RENAL/KIDNEY ☐ BLADDER
- ☐ TESTICLE (WITH COLOR FLOW IF NECESSARY) ☐ GB/LIVER ☐ RENAL ARTERY ☐ PROSTATE
- ☐ THYROID ☐ BREAST ☐ BREAST LOCALIZER ☐ OTHER: _____
- ☐ SCROTUM ☐ ABI OR PPG ☐ SEGMENTAL PRESSURE ☐ HEMODIALYSIS PRESSURE
- ☐ **COLOR DOPPLER** ☐ AORTA ☐ VENOUS ☐ CAROTIDS ARTERIAL (COLOR FLOW IF NECESSARY)
- ☐ **OB** ☐ EDD ☐ LESS THAN 14 WEEKS ☐ MORE THAN 14 WEEKS ☐ LIMITED ☐ BIOPHYSICAL

CT

- ☐ HEAD ☐ CHEST ☐ PELVIS ☐ C-SPINE
- ☐ ABD/PEL ☐ SINUS ☐ ST NECK ☐ T-SPINE
- ☐ ABDOMEN ☐ CH/ABD/PEL ☐ FACIAL ☐ L-SPINE
- ☐ EXTREMITY ☐ UPPER ☐ LOWER ☐ LT ☐ RT
- ☐ RENAL STONE ☐ OTHER:_____

CTA

- ☐ ABDOMEN ☐ ABDOMEN/PELVIS
- ☐ CAROTID ☐ HEAD ☐ CHEST
- ☐ EXTREMITY ☐ UPPER ☐ LOWER ☐ L ☐ R
- ☐ AORTA W/RUNOFF
- ☐ OTHER: _____

NUC

- ☐ 3 PHASE BONE ☐ TOTAL BODY BONE ☐ V/Q SCAN ☐ MUGA
- ☐ SENTINEL NODE ☐ THYROID UPTAKE ☐ PARATHYROID ☐ GASTRIC EMPYTING
- ☐ HIDA SCAN ☐ RENAL (WITH LASIX) ☐ RENAL (WITHOUT LASIX) ☐ MYOCARDIAL SPECT

MRI

- ☐ LUMBAR ☐ BRAIN ☐ BRAIN STEALTH ☐ BREAST ☐ CERVICAL
- ☐ ABDOMEN ☐ MRCP ☐ PELVIS ☐ THORACIC ☐ ORBIT/FACE/NECK
- ☐ EXTREMITY ☐ UPPER ☐ LOWER ☐ RT ☐ LT ☐ MRA/HEAD/COW ☐ MRA NECK/CAROTID

PROCEDURES

☐ MYELOGRAM ☐ LUMBAR PUNCTURE ☐ ARTHROGRAM ☐ HYSTEROSALPINGOGRAM ☐ BIOPSY/ASPIRATION

Contrast will be added as necessary to optimize the diagnostic capability of the exam. Additional studies will be performed as medically necessary to optimize the diagnostic capability of the study that is being performed (e.g.: x-rays for an abnormal bone scan.) Signing this form indicates your agreement of the above.

TELEPHONE REPORT #_____

_____ PROVIDER SIGNATURE (signature stamps are not valid)

_____ DATE

_____ TIME

ADDRESSOGRAPH

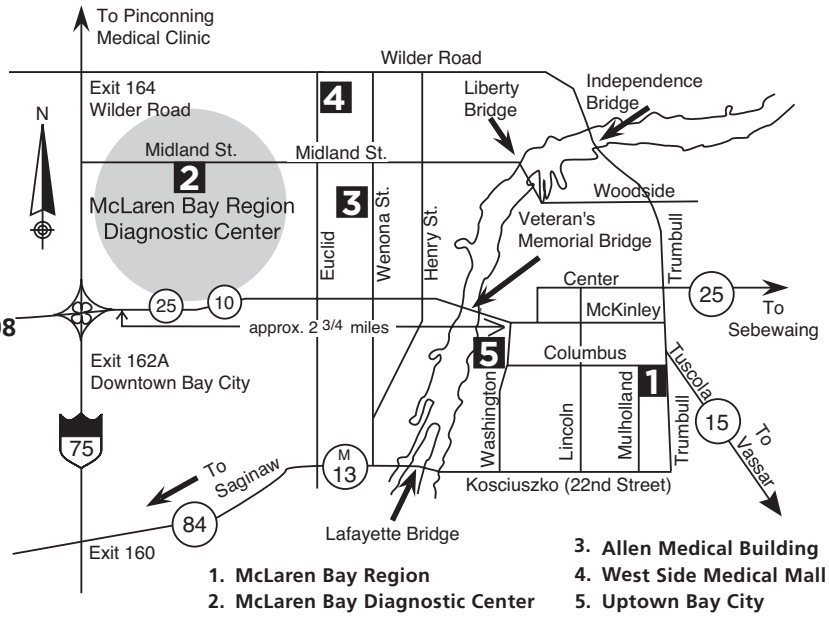
100A

OUTPATIENT RADIOLOGY ORDER FORM

McLaren
BAY REGION

DOING WHAT'S BEST.

- ☐ **Mclaren Bay Region,**
  1900 Columbus Avenue, Bay City MI, 48708
  X-Ray, CT, Ultrasound, NM, PET, and MRI
- ☐ **Mclaren Bay Diagnostic Center,**
  3175 W. Professional Drive, Bay City, MI 48706
  Ultrasound, Bone Density, and Mammography
- ☐ **Diagnostic Imaging – West Side Medical Mall,**
  4175 N. Euclid, Bay City, MI 48706
  CT and X-Ray
- ☐ **Diagnostic Imaging – Uptown Bay City,**
  4 Columbus Avenue, Suite 120, Bay City, MI 48708
  X-Ray
- ☐ **Mclaren Bay Region – Midland**
  801 Joe Mann Boulevard, Midand, MI 48642
  X-Ray and Ultrasound
- ☐ **Mclaren Bay Region – West Branch**
  2110 M-76, West Branch, MI 48661
  X-Ray, CT, Ultrasound, NM, MRI,
  Mammography, and Bone Density



PATIENT INSTRUCTIONS:

Please bring your order form, photo ID, medical insurance card(s) and any previous related exams (not completed at McLaren facility) to your appointment.

EXAM PREPARATIONS:

Barium Enema
Day before the exam:

1. One 8 oz. glass of water every 2 hrs.
2. Clear liquids all day (NO Dairy).
3. Following the clear liquid lunch, the patient shall drink on chilled 10 oz. bottle of Magnesium Citrate.
4. At 1:00 pm and 3:00 pm, the patient shall drink one chilled 10 oz. bottle of Magnesium Citrate.
5. At 1:00 pm and 3:00 pm, drink an 8 oz. glass of cold water.
6. At 4:00 pm, ingest Dulcolax laxatives.
7. Clear liquid supper (NO Dairy).
8. At bedtime, drink 8 oz. cold water.
9. Nothing to eat or drink after midnight.

IVP
Day before the exam:

1. Clear liquid lunch/supper.
2. At 5:00 pm, ingest 3 Dulcolax laxatives.
3. Nothing to eat or drink after midnight.

Upper GI, Barium Swallow, and/or Small Bowel Exam
Day before the exam:

1. Clear liquid supper.
2. Nothing to eat or drink after midnight.
3. No gum chewing.

Myelogram, Lumbar Puncture, or Arthrogram

1. Nothing to eat or drink after midnight day before.
2. No blood thinners 5 days prior.
3. Must have driver (Myelogram and LP).

Ultrasound

- ☐ **Pelvis and OB** – Must finish 4 - 6 8 oz. glasses of fluid 1 hr. before appointment. Do not urinate. Your bladder must be very full.
- ☐ **Abdomen (Aorta, GB & Kidney)** – Nothing to eat or drink for 8 hours prior to the exam.

CT

- ☐ **Abdomen & Pelvis** – Nothing to eat for 4 hours prior to the exam. Based on diagnosis, you may be required to drink Barium for 1 1/2 hours prior to imaging.

Nuclear Medicine

- ☐ **Myocardial** – Nothing to eat or drink 4 hours before the exam and NO caffeine (any form) for 12 hours before the exam. Please check with your physician regarding any mediations to be withheld.
- ☐ **HIDA Scan** – Nothing to eat or drink 4 hours before the exam, no opiate based pain medications 4 hours before the exam, eat a fatty snack (milk, ice cream, fried foods, meats, etc.) the evening before the exam.
- ☐ **Gastric Emptying** – Nothing to eat or drink 8 hours before the exam.
- ☐ **Renal Scan** – The patient should arrive well hydrated from the exam (drink extra fluids).
- ☐ **Renal Scan with Lasix** – The patient should arrive well hydrated from the exam (drink extra fluids). Diuretics should not be taken the morning of the exam.
- ☐ **Thyroid** – Nothing to eat or drink 4 hours before the first visit on the first day of the exam. No thyroid medications for 6 weeks prior. No compounds or medications containing IODINE in any form shall be taken 6 weeks prior, this includes IV contrast. No multivitamins for 2 weeks prior, no Cytomel 3 weeks prior, no Estrogens 3 weeks prior, and antihistamines shall be withheld for 1 week prior unless they contain iodine in which case they shall be withheld for 6 weeks.