

Outpatient Radiology Order Form

Please complete all fields.

Patient Name _____ DOB _____ Patient Phone # _____

Clinical Information/Symptoms _____

Diagnosis Code(s) _____

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=VidantHealth>

Radiographic Exam

- 2 view chest PA/lateral
- Single view chest
- Abdomen KUB - 1 view
- Abdomen 2 view
- Abdomen acute series
- Spine: Cervical Thoracic
 Lumbar Complete
 AP/lateral only
 Flex/extension
- Scoliosis Pelvis
- Hip with 1 view:
 R L Bilateral
- Ribs with 1 chest view Orbits
- Neck soft tissue Bone age
- Joints and extremities
 R: _____
 L: _____
- Weight bearing
- Fluoroscopy:

Nuclear Medicine

- Bone, total body Bone, three phase
- Indium white blood cell
- Thyroid uptake/scan
- Total body iodine
- Thyroid therapy ablation
 Hyperthyroidism Cancer
- Parathyroid/sestamibi
- Liver/spleen
- Renal: w/ Lasik w/o Lasik
- GI: Emptying Meckles
- Hepatobiliary (HIDA):
 w/ CCK w/o CCK Leak
- Lung/VQ: PE Differential
- Cardiac:
 Stress test MUGA Infarct

PET

- Body PET (tumor)
- Identify primary cancer: _____

PET continued

- Indication for PET tumor scan:
- Diagnosis Initial treatment
 - Subsequent treatment
 - Brain: Seizure Necrosis

Ultrasound

- Abdomen complete
(liver, GB, pancreas, kidneys)
- Abdomen limited
(RUQ-GB, liver, pancreas)
- Pelvis transvaginal/transabd.
(uterus/ovaries)
- Pelvis *(general)*
- Aorta
- Renal *(kidneys, bladder)*
- Renal transplant
- Renal doppler
- Carotid doppler
- Obstetrical
- Testicular/scrotum
- Extremity
- Venous doppler: R L
 Bilateral Lower extremity
 Upper extremity
- Venous insufficiency
- Soft tissue other than head/neck:
Specify _____
- Thyroid
- TIPS evaluation
- Other:
Specify _____

CT Scan

- Designate: _____
- Without contrast With contrast
 - 3D reconstruction

Neuro:

- Head/brain Facial bones
- Orbits Temporal bones
- Sinuses Brain lab
- Soft tissue neck

CT Scan continued

Neuro continued:

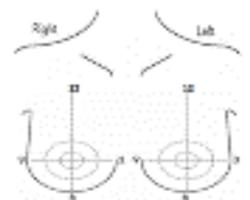
- Spine:
 Cervical Thoracic Lumbar
- CTA head (COW) CTA neck (carotids)
- Craniocytosis

Body:

- Chest CTA chest (PE/Aorta)
- Low dose chest for cancer screening
- High resolution chest
- Calcium scoring
- Cardiac (heart) TAVR protocol
- Watchman/Cardiac vein mapping
- Abdomen/pelvis
- Abdomen Pelvis
- Renal stone protocol
Allow IV contrast if needed
- Enterography
- CT virtual colonography
- CTA abdomen/pelvis
- CTA abdomen *(liver/pancreas/renal/aorta)*
- Extremity: R L
Specify _____
- CTA aorta-iliac femoral runoff

Mammography

- Screening Diagnostic
- Breast ultrasound
- Core biopsy/aspiration
(if indicated by radiologist)
- Bone density DEXA
- Breast TAG placement
- Breast wire localization



Other

- Other procedure not listed: _____

Comments: _____

Provider signature: _____ Provider name: _____

Supervising MD/DO (required for APP orders): _____

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