Outpatient Radiology Order Form

ECU HEALTH

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=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:

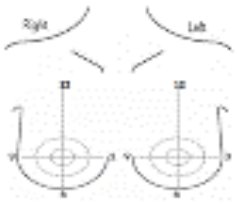
- ☐ Spine: ☐ *Cervical* ☐ *Thoracic* ☐ *Lumbar*
- ☐ CTA head *(COW)* ☐ CTA neck *(carotids)*
- ☐ Craniocytosis

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 *(if applicable)*:_____

Radiology Scheduling Questionnaire

ECU HEALTH

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