Outpatient Radiology Order Form

Please complete all fields.

ECU HEALTH

Patient Name_____ DOB_____ Phone_____

Clinical Information/Symptoms_____

Diagnosis Code(s)_____ CPT Code_____

Radiographic Exam

- ☐ 2 view chest
- ☐ 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/ Lasix* ☐ *w/o Lasix*
- ☐ GI: ☐ *Emptying* ☐ *Meckles*
- ☐ Hepatobiliary (HIDA): ☐ *w/ CCK* ☐ *w/o CCK* ☐ *Leak*
- ☐ Lung/VQ: ☐ *PE* ☐ *Differential*
- ☐ Cardiac: ☐ *Stress test* ☐ *MUGA* ☐ *PYP*
- ☐ Brain-Parkinson's

PET

- ☐ Body PET (tumor)

Identify primary cancer:_____

☐ *Amyvid* ☐ *Dotatate* ☐ *PSMA*

Indication for PET tumor scan:

- ☐ Diagnosis ☐ Initial treatment
- ☐ Subsequent treatment
- ☐ Brain: ☐ *Seizure* ☐ *Necrosis* ☐ *Alzheimer's*

Ultrasound

- ☐ Chest ☐ LUQ
- ☐ Abdomen complete *(liver, GB, pancreas, kidneys, spleen)*
- ☐ Abdomen limited *(liver, RUQ-GB, pancreas)*
- ☐ Pelvis transvaginal/transabdominal *(uterus, ovaries)*
- ☐ Pelvis *(general)*
- ☐ Aorta
- ☐ Renal *(kidneys, bladder)*
- ☐ Renal transplant
- ☐ Renal doppler
- ☐ Pancreatic transplant
- ☐ Carotid doppler ☐ Arterial doppler
- ☐ Venous doppler: ☐ *R* ☐ *L* ☐ *Bilateral* ☐ *Lower extremity* ☐ *Upper extremity*
- ☐ Extremity ☐ Flow volume
- ☐ Obstetrical
- ☐ Testicular/scrotum
- ☐ Venous insufficiency
- ☐ Soft tissue other than head/neck: *Specify:*_____
- ☐ Thyroid
- ☐ TIPS evaluation
- ☐ Pediatric: ☐ *TCD* ☐ *Cranial/Head*
- ☐ Other: *Specify:*_____

CT Scan

Designate:_____

☐ *Without contrast* ☐ *With contrast*

☐ *3D reconstruction*

Neuro:

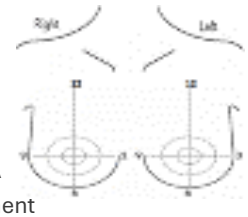
- ☐ Head/brain ☐ Facial bones
- ☐ Sinuses ☐ Brain lab
- ☐ Craniosynostosis
- ☐ CTA head *(COW)* ☐ CTA neck *(carotids)*
- ☐ Spine: ☐ *Cervical* ☐ *Thoracic* ☐ *Lumbar*
- ☐ Soft tissue neck

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 specified:_____

Comments:_____

Provider signature:_____ Provider name:_____

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

Radiology Scheduling Questionnaire

ECU HEALTH

For all procedures, please complete the following:

Patient weight:_____

Primary Insurance Provider:_____ Authorization #:_____ Authorization Date:_____

Secondary Insurance Provider:_____ Authorization #:_____ 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

1. Does the patient have a contrast allergy? ☐ *YES* ☐ *NO*

CT

1. 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.
2. Does the patient have a contrast allergy? ☐ *YES* ☐ *NO*
   If yes, patient needs to be pre-medicated per Radiology Protocol.
3. Does the patient have life-long asthma? ☐ *YES* ☐ *NO*
   If yes, follow patient pre-medication prep policy.
4. Does the patient have a port? ☐ *YES* ☐ *NO*
5. Is this order for the Renal Donor Protocol? ☐ *YES* ☐ *NO*

Low-Dose CT

1. Current smoking status: ☐ *Every day* ☐ *Some days* ☐ *Never* ☐ *Passive smoke exposure, never smoker* ☐ *Heavy smoker* ☐ *Light smoker* ☐ *Former; how many years ago did they quit:*_____ ☐ *Smoker, status unknown* ☐ *Unknown*
2. Actual pack-year smoking history (yrs x packs/day): _____pack-years
3. Does the patient show any signs or symptoms of lung cancer? ☐ *YES* ☐ *NO*
4. Is this the first (baseline) CT or an annual exam? ☐ *Baseline* ☐ *Annual*
5. Is there documentation of shared decision-making? ☐ *YES* ☐ *NO*
6. Did the patient receive cessation guidance? ☐ *YES* ☐ *NO*

Mammogram

1. Does the patient have pain, tenderness, lumps? ☐ *YES* ☐ *NO*
2. Date of last mammogram:_____
3. Does the patient have breast implants? ☐ *YES* ☐ *NO*
4. Interpreting practice: ☐ *ERI* ☐ *CBIS*
5. Okay to proceed with additional imaging as needed? ☐ *YES* ☐ *NO*

Nuclear Medicine/PET

1. Is the patient currently breast-feeding? ☐ *YES* ☐ *NO*
2. Date of last sexual activity:_____
3. Is there suspected lower extremity involvement? ☐ *YES* ☐ *NO*
4. Is there suspected head extremity involvement? ☐ *YES* ☐ *NO*
5. Is there suspected liver involvement? ☐ *YES* ☐ *NO*
6. Is this a new cancer? ☐ *YES* ☐ *NO*
7. Is the patient diabetic? ☐ *YES* ☐ *NO*
8. Do they have an insulin pump? ☐ *YES* ☐ *NO*
9. Is this for treatment planning? ☐ *YES* ☐ *NO*

Please note: *Additional information may need to be collected prior to scheduling.*