☐ STAT

☐ Call or ☐ Fax Results: #

Summit Medical Center Diagnostic Imaging Order Form

Scheduling (307) 232-4070 Fax: (307) 215-0753

Patient Information

Legal Name: _____ Birthdate: _____

Preferred Name: _____

Address: _____ Phone: _____

Please fax this form and a copy of the patient's demographics/insurance information to SMC scheduling - (307) 215-0753

REQUIRED

Signs and Symptoms: _____

ICD-10 Codes (Medicare Only) _____ **ORDERING PHYSICIAN:** _____

Physician's Signature: _____ **Date:** _____

X-RAY

- ☐ Chest **O** 1V or **O** 2V
- ☐ Ribs
- ☐ Abdomen **O** 1V KUB or **O** 2V
- ☐ Acute Abdominal Series 3V (incl. CXR)
- ☐ Soft Tissue Neck
- ☐ Clavicle **O** RT or **O** LT
- ☐ AC Joints
- ☐ C-Spine **O** 2V-3V **O** 4V-5V **O** Flex/Ext
- ☐ T-Spine **O** 2V **O** 3V
- ☐ L-Spine **O** 2V-3V **O** 4V-5V **O** Flex/Ext
- ☐ Pelvis
- ☐ Hip **O** RT or **O** LT
- ☐ Sacrum/Coccyx
- ☐ Upper Extremity **O** RT or **O** LT
  Specify_____
- ☐ Lower Extremity **O** RT or **O** LT
  Specify_____
- ☐ **O** Sinus **O** Facial Bones **O** Nasal **O** Skull **O** Orbits
- ☐ Skeletal Survey
- ☐ Bone Age
- ☐ OTHER_____

No SCOLIOSIS Series

MAMMOGRAPHY/BREAST

- ☐ Screening Mammo IMPLANTS ○ Y or ○ N
- ☐ Diagnostic Mammo **O** RT **O** LT OR **O** Bilat (ORDER BILAT IF NO PRIOR MAMMO w/in 1 YEAR)
- ☐ **Breast US** **O** RT **O** LT OR **O** Bilat
- ☐ **Breast US If Indicated** **O** RT **O** LT OR **O** Bilat

ULTRASOUND

- ☐ Abdomen complete
- ☐ Abdomen limited

Specify Organ:_____

- ☐ GB **O W/CCK O W/O CCK**
- ☐ Aorta
- ☐ Carotid
- ☐ Other:
- ☐ Palpable lump

Specify Site:_____

- ☐ Extremity Non-Vascular
  O RT or **O** LT
  O Upper or **O** Lower
- ☐ Venous Doppler for DVT
  O RT or **O** LT
  O Upper or **O** Lower
- ☐ Soft Tissue Neck / Thyroid
- ☐ Soft Tissue Neck / Back
- ☐ Hernia

Specify Location:_____

- ☐ Testicular
- ☐ Pelvic
  O Transvaginal
  O Transabdominal
- ☐ OB Less than 14 Weeks Dating
- ☐ OB Greater than 14 Week **Anatomy**
- ☐ OB Limited

Specify Location:_____

- ☐ OB Follow-up Growth
- ☐ **Cervical Length**
- ☐ Biophysical Profile w/o NST
- ☐ Umbilical Artery
- ☐ MCA Dopplers

CT

☒ Perform BUN & Creatinine if meets criteria.

☐ BUN & Creatinine performed within 30 days. Will send labs

O WO IV Contrast

O W IV Contrast

O WO/W IV Contrast

O Oral Contrast (Abd. and/or pelvis only)

- ☐ Abdomen
- ☐ Abdomen & Pelvis
- ☐ Stone Protocol (Abd/Pelvis No Contrast)
- ☐ Chest (no cardiac)

O Routine O PE O Nodule

- ☐ Low Dose Lung Screening
- ☐ **Calcium Scoring**
- ☐ Head
- ☐ Sinus **O Routine or O Stealth**
- ☐ Facial Bones
- ☐ Orbits
- ☐ Mandible
- ☐ Soft Tissue Neck
- ☐ Pelvis **O Mass or O Bony**
- ☐ Extremity Upper **O** RT or **O** LT
  Specify Part_____
- ☐ Extremity Lower **O** RT or **O** LT
  Specify Part_____
- ☐ CONFORMIS
  Specify Part_____
  O RT or **O** LT
- ☐ PROPHECY
  Specify Part_____
  O RT or **O** LT
- ☐ ZIMMER
  Specify Part_____
  O RT or **O** LT
- ☐ C-Spine
- ☐ T-Spine
- ☐ L-Spine
- ☐ CT Angiography
  O Gated
  Specify Exam:_____
- ☐ OTHER_____

MRI

☒ **IF Meets Criteria, please perform X-RAY ORBITS, Foreign Body for MRI Screening**

O WO IV Contrast
O WO/W IV Contrast
O Arthrogram

- ☐ Brain
- ☐ Pituitary
- ☐ IAC
- ☐ Orbits
- ☐ Soft Tissue Neck
- ☐ MRA
  Specify:_____
- ☐ MRV
  Specify:_____
- ☐ Abdomen
- ☐ MRCP
- ☐ C-Spine
- ☐ T-Spine
- ☐ L-Spine
- ☐ Pelvis
- ☐ Pelvis Sports Hernia
- ☐ Female Pelvis
  Specify:_____
- ☐ Sacrum
- ☐ Extremity Upper **O** RT or **O** LT
  Specify Part:_____
- ☐ Extremity Lower **O** RT or **O** LT
  Specify Part:_____
- ☐ OTHER_____

SUMMIT MEDICAL CENTER
Elevating the Standards of HealthCare.

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