OUTPATIENT RADIOLOGY TEST REQUEST

SEE BACK OF FORM FOR AVAILABLE TEST LOCATIONS

Patient legal name	Phone number	Date of birth	☐ Male ☐ Female (pregnant: ☐ Y ☐ N # wks)
Scheduled test date / Scheduled test time AM PM	Payor / Insurance	Authorization number	Encounter ☐ Initial ☐ Subsequent

Accident ☐ Yes ☐ No
Describe:

History of cancer ☐ Yes ☐ No
Describe:

Evaluation of known mass ☐ Yes ☐ No Palpable: ☐ Yes ☐ No
Describe:

Implanted devices ☐ Yes ☐ No
Describe:

Prior surgeries ☐ Yes ☐ No
Describe:

Specific area(s) of interest (i.e. liver, kidneys etc.):

☐ Phone report to:_____ ☐ Fax report to:_____
☐ Hold patient ☐ Priority dictate: Can be accessed by Listen Line 57449 ☐ CD to go

Copy report to: MD / DO

DOCUMENTED CLINICAL FINDINGS - HPI describe: (diagnosis, signs/symptoms, pain, injury, positive pathology, disease and/or complaints)

Comments and/or procedures not listed:

YOU MUST BRING THIS FORM WITH YOU

HEAD / NECK
- ☐ Skull
- ☐ Facial Bones
- ☐ Nasal Bones
- ☐ Mandible
- ☐ Sinuses
- ☐ Neck, Soft Tissue
- ☐ Orbits
- ☐ Other_____

CHEST / ABDOMEN
- ☐ Chest
- ☐ Ribs UNI R / L BIL
- ☐ Abd 2 View
- ☐ Abdomen (KUB)
- ☐ Abdomen Complete w/ 1 View Chest
- ☐ Bone Age Study
- ☐ Bone Survey ☐ Metabolic ☐ Metastatic
- ☐ Skeletal Survey Peds ☐ Congen Anom ☐ Trauma
- ☐ Other_____

UPPER EXTREMITY (Circle R/L/BOTH)
- ☐ Clavicle R / L
- ☐ AC Joints R / L
- ☐ Shoulder R / L
- ☐ Humerus R / L
- ☐ Elbow R / L
- ☐ Forearm R / L
- ☐ Wrist R / L
- ☐ Hand R / L
- ☐ Finger(s) R / L
- ☐ Scapula R / L
- ☐ Other_____

LOWER EXTREMITY (Circle R/L/BOTH)
- ☐ Hip R / L
- ☐ Femur R / L
- ☐ Femoral Align (FFCHC, POMH)
- ☐ Knee R / L
- ☐ Tibia - Fibula R / L
- ☐ Ankle R / L
- ☐ Foot R / L
- ☐ Heel R / L
- ☐ Toe(s) R / L

SPINE / PELVIS
- ☐ Pelvis ☐ SI Joints
- ☐ Sacrum-Coccyx ☐ Postural Study
- ☐ Spine Cervical Complete
- ☐ Cervical 1 View
- ☐ Cervical AP / LAT
- ☐ Cervical LAT / FLEX / EXT
- ☐ Cervical AP / LAT / FLEX / EXT
- ☐ Spine Complete AP / LAT
- ☐ Lumbar Complete
- ☐ Lumbar 2V
- ☐ Lumbar AP / LAT / FLEX / EXT
- ☐ Lumbar LAT / FLEX / EXT
- ☐ Spine Thoracic
- ☐ Scoliosis Standing (FFCHC, CAD, GRY, POMH, Manistee)

The procedures listed below must be scheduled in advance. Exams highlighted in red require preparations, which are listed on the back

COMPUTED TOMOGRAPHY (CT)
I.V. Contrast will be prescribed based on clinical indications and information.
☐ **Do Not give IV contrast** _____ (indicate reason)
Most Recent Weight: _____
No Yes
☐ ☐ Prior contrast reaction
If yes, need steroid prep prior to scan
☐ ☐ Current treatment for acute asthma
If yes, need steroid prep prior to scan
☐ ☐ Known renal insufficiency
Most recent GFR level: _____date:_____
- ☐ Sinus
- ☐ Head
- ☐ Neck

Spine: ☐ Cervical ☐ Thoracic ☐ Lumbar
- ☐ Chest _____
- ☐ Cardiac
- ☐ Abdomen (Diaphragm to iliac crest)
- ☐ Abdomen & Pelvis
- ☐ Pelvis
- ☐ Upper Extremity ___ L ___ R
- ☐ Lower Extremity ___ L ___ R
- ☐ CT Special Procedures
- ☐ CTA _____
- ☐ CT other: _____
- ☐ _____
- ☐ _____
- ☐ _____

GASTROINTESTINAL
- ☐ Esophagram ☐ Sniff Test
- ☐ Video Fluoro ☐ Small Bowel
- ☐ Upper GI

(CONT. GASTROINTESTINAL)
- ☐ Barium Enema
- ☐ Defecography
- ☐ Other_____

GENITOURINARY
- ☐ Cystogram
- ☐ Voiding Cystourethrogram
- ☐ Hysterosalpingogram
- ☐ Other_____

INTERVENTIONAL RADIOLOGY
- ☐ Perm Cath Removal
- ☐ Perm Cath Insertion
- ☐ Other Interventional Procedures at MMC
- ☐ Other_____

BREAST IMAGING
- ☐ Bone Densitometry
- ☐ Mammogram
- ☐ Screening ☐ Diagnostic
___ Unilateral ___ L ___ R ___ Bilateral
- ☐ Ultrasound Breast
___ Unilateral ___ L ___ R ___ Bilateral
- ☐ Screening Whole Breast Ultrasound
- ☐ Cyst Aspiration
- ☐ Needle Loc
- ☐ Stereotactic Biopsy
- ☐ Core Biopsy
- ☐ Other_____

MISCELLANEOUS
- ☐ Arthrogram
☐ Shoulder ___ L ___ R
☐ Hip ___ L ___ R

MRI / MRA
I.V. Contrast will be prescribed based on clinical indications and information.
Head: ☐ Brain ☐ Orbits ☐ Sella ☐ IAC
- ☐ Neck Soft Tissue

Spine: ☐ Cervical ☐ Thoracic ☐ Lumbar
- ☐ Chest
- ☐ Heart
- ☐ Breast
- ☐ Abdomen *specify:*_____
- ☐ Pelvis

Musculoskeletal Joint
Upper Extremity ___ L ___ R
Lower Extremity ___ L ___ R
___ with X-ray Arthrogram
- ☐ Upper Extremity ___ L ___ R
- ☐ Lower Extremity ___ L ___ R
- ☐ MRI with Anesthesia ☐ MRI w/o Anesthesia (need H&P within 30 days of appt.)
- ☐ MRA _____
- ☐ MRV _____
- ☐ Other_____

MYELOGRAM
- ☐ Cervical (with CT)
- ☐ Thoracic (with CT)
- ☐ Lumbar (with CT)
- ☐ Complete (with CT)
- ☐ Discogram
- ☐ Other_____

ULTRASOUND / VASCULAR LAB
use Ultrasound Order Form #10413

NUCLEAR MEDICINE
- ☐ MYO MULTI SPECT W/STRESS
- ☐ MYO MULTI Pharmacologic ☐ *Lexiscan*
- ☐ Bone Scan ☐ *3phase* ☐ *SPECT* ☐ *Whole body* (cancer protocol)
- ☐ White Blood Cells ☐ *w/SPECT*
- ☐ MIBG Scan ☐ *w/SPECT*
- ☐ NM O ctreoscan ☐ *w/SPECT*
- ☐ Parathyroid Imaging ☐ *w/SPECT*
- ☐ Pulm Perfusion / Aerosal / Ventilation (VQ)
- ☐ Pulm Perfusion / Ventilation Quantitative
- ☐ Bowel Imaging ☐ *Meckels* ☐ *GI Bleed*
- ☐ Brain w/SPECT(Datscan)
- ☐ Gallbladder Imaging ☐ *w/stimulation*
- ☐ Cardiac Blood Pool (MUGA)
- ☐ Gastric Emptying ☐ *Solid*
- ☐ I^{131} Total Body Scan
☐ *w/treatment* ☐ *w/retention + treatment*
☐ *w/thyrogen* ☐ *w/thyrogen + treatment*
- ☐ I^{131} Therapy ☐ *Hyperthyroid* ☐ *Cancer, Thyroid*
- ☐ Thyroid + Uptake
- ☐ Lymph Gland Imaging (Sentinel Node)
- ☐ Lymph Gland Melanoma w/Spect CT
- ☐ Renal w/Flow + diuretic

PET SCAN-use PET SCAN Order Form #6532

Other_____

ORDERING PROVIDER (PRINT):

PROVIDER SIGNATURE: **DATE:** **TIME:**

PLEASE CALL YOUR DESIRED FACILITY TO MAKE SURE THEY DO YOUR ORDERED TESTING.
IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT, PLEASE CALL THE APPROPRIATE FACILITY.

SCHEDULING (for facilities listed below): Phone: 800-968-9292 Fax: 231-935-3473

- ☐ MUNSON HEALTHCARE CHARLEVOIX HOSPITAL
- ☐ KALKASKA MEMORIAL HEALTH CENTER (KMHC)
- ☐ FOSTER FAMILY COMMUNITY HEALTH CENTER (FFCHC)
- ☐ MUNSON HEALTHCARE CADILLAC HOSPITAL (CAD)
- ☐ MUNSON HEALTHCARE GRAYLING HOSPITAL (GRY)
  - ☐ Roscommon ☐ Prudenville
- ☐ MUNSON HEALTHCARE MANISTEE HOSPITAL
- ☐ MUNSON MEDICAL CENTER (MMC - Main Lobby)
- ☐ MUNSON PROFESSIONAL BLDG (MPB)
- ☐ PAUL OLIVER MEMORIAL HOSPITAL (POMH)
- ☐ SMITH FAMILY BREAST HEALTH CENTER
- ☐ MUNSON HEALTHCARE OTSEGO MEMORIAL HOSPITAL (OMH)

- ☐ INTERVENTIONAL RADIOLOGY **(MMC - Main Lobby)**
  Phone: 231-935-2861 Fax: 231-935-2862
- ☐ INTERVENTIONAL RADIOLOGY **(OMH)**
  Phone: 989-731-2100 Fax: 231-213-8713

Please follow these instructions carefully. Failure to follow these may result in the need to reschedule your exam.
There are different preparations for children, please call the Radiology Department 231-935-7200 or view the Radiology site at:
http://www.munsonhealthcare.org/clinical_svcs/radiology/radiology.php

IF THERE IS ANY CHANCE YOU COULD BE PREGNANT PLEASE INFORM YOUR PHYSICIAN

☐ **BARIUM ENEMA:** Obtain the Bowel Preparation Instructions from your doctor. Please read and review the instructions and obtain your preparation at least one week prior to your procedure date. The prep must be started 24 hours prior to the exam. The exam takes approx. 1 hour.

☐ **BONE SCAN:** The examination will be done $2^{1/2}$ hours after a small injection. You may leave the hospital during the waiting period. The exam takes approx. 1 hour.

☐ **DEFECOGRAPHY:** Clear liquids from midnight the night before the examination. Fleet enema 3 to 4 hours before scheduled exam time. You need to arrive 1 hour before the appointment time to drink the barium, which takes 1 hour to get down to the bowel.

☐ **ESOPHAGRAM:**
a. Nothing to eat or drink 3 hours prior to exam.
b. Esophagram studies usually take less than 1 hour.

☐ **UPPER GI / SMALL BOWEL STUDIES:**
a. Light supper on the day prior to the exam.
b. Nothing to eat or drink (including water) after 9:00 p.m. prior to exam.
c. Upper GI studies usually take less than 1 hour.
d. Small Bowel studies may vary in length of time, it depends on how long it takes the barium to get through the small bowel.

☐ **GASTRIC EMPTYING SCAN:** Nothing to eat or drink (including water) after 12:00 midnight prior to exam. This exam takes up to 4 hours.

☐ **GALLBLADDER IMAGING:** Discontinue eating, drinking and narcotics 4 hours before exam. This exam takes approx. 60 to 90 min.

☐ **THYROID UPTAKE & SCAN:** This examination is done over a two day period. Discontinue synthroid thyroid medication at least 6 weeks before the examination. Discontinue Cytomel 3 weeks before exam. Discontinue Propylthiouracil or Tapazole one week before exam. No iodinated contrast 3 months before scan. You will be given I^{123} capsules at the time your procedure is scheduled. Return 4-6 hours later for the uptake procedure which takes about 15-30 min. Return to the department the following day for the remaining scan which takes about 5-30 min.

☐ **I^{131} TOTAL BODY SCAN:** Initial studies are performed 6 weeks post surgery. Yearly follow-ups may be done with Thyrogen per request of referring physician, or you must discontinue synthroid thyroid medication at least 6 weeks before the examination and should not have iodinated contrast within 3 months of the scan.

☐ **INTRAVENOUS PYELOGRAM:**
a. Castor oil, 1-½ ounces, or one 10 ounce bottle of magnesium citrate at 7:00 p.m. on the evening prior to the examination.
b. After 9:00 p.m. clear liquids only, (coffee, tea, or clear fruit juice) no solids or milk products.

☐ **MAMMOGRAMS:** Do not use powders, deodorants or creams on your underarms or breasts since these may interfere with the study. Previous images needed. Bring previous images for exam if done outside Munson Healthcare system.

☐ **MRI WITH ANESTHESIA:** **DO NOT** eat or drink after midnight.

☐ **MYELOGRAM:** At MMC you will be receiving a call from the Pre-Procedure Clinic with instructions. If you haven't received a call prior to the day before, call them at 231-935-7010. This exam requires an extended stay. Lumbar exams require a 4 hour (approx.) stay, cervical exams require a 4 hour (approx.) stay. At GRY you will be pre-admitted.

☐ **MYOCARDIAL PERFUSION IMAGING:** Follow instructions from the Non-Invasive Cardiology Department or Central Scheduling for preparation for the stress test. This multiple stage exam takes a total of approximately 3 to 4 hours. No caffeine/decaf (coffee, tea, pop or chocolate) after 12 pm. For Persantine and Adenosine studies, no caffeine/decaf for 24 hours before test.

Your doctor has ordered an x-ray procedure to be done at a Munson Healthcare facility. Private radiology practices partner with Munson Healthcare and provide supervision of your test and a written report to your doctor. Radiologists are doctors with 4-6 years of additional training in radiology. They are involved in your care when you come to the x-ray department, whether they personally perform your test or supervise a technologist. You will receive two statements for your test, one from the hospital and one from the Radiologists. As a reminder, all images remain the property of the facility.