

OUTPATIENT RADIOLOGY TEST REQUEST

SEE BACK OF FORM FOR AVAILABLE TEST LOCATIONS

Patient legal name		Phone number		Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female (pregnant: <input type="checkbox"/> Y <input type="checkbox"/> N # wks)	
Scheduled test date	Scheduled test time	AM PM	Payor / Insurance	Authorization number	Encounter	<input type="checkbox"/> Initial <input type="checkbox"/> Subsequent
Accident <input type="checkbox"/> Yes <input type="checkbox"/> No			History of cancer <input type="checkbox"/> Yes <input type="checkbox"/> No			
Describe: Evaluation of known mass <input type="checkbox"/> Yes <input type="checkbox"/> No Palpable: <input type="checkbox"/> Yes <input type="checkbox"/> No			Describe: Implanted devices <input type="checkbox"/> Yes <input type="checkbox"/> No			
Describe: Prior surgeries <input type="checkbox"/> Yes <input type="checkbox"/> No			Describe: Specific area(s) of interest (i.e. liver, kidneys etc.):			
<input type="checkbox"/> Phone report to: _____ <input type="checkbox"/> Fax report to: _____ <input type="checkbox"/> Hold patient <input type="checkbox"/> Priority dictate: Can be accessed by Listen Line 57449 <input type="checkbox"/> 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 <input type="checkbox"/> Skull <input type="checkbox"/> Facial Bones <input type="checkbox"/> Nasal Bones <input type="checkbox"/> Mandible <input type="checkbox"/> Sinuses <input type="checkbox"/> Neck, Soft Tissue <input type="checkbox"/> Orbits <input type="checkbox"/> Other _____	CHEST / ABDOMEN <input type="checkbox"/> Chest <input type="checkbox"/> Ribs UNI R / L BIL <input type="checkbox"/> Abd 2 View <input type="checkbox"/> Abdomen (KUB) <input type="checkbox"/> Abdomen Complete w/ 1 View Chest <input type="checkbox"/> Bone Age Study <input type="checkbox"/> Bone Survey <input type="checkbox"/> Metabolic <input type="checkbox"/> Metastatic <input type="checkbox"/> Skeletal Survey Peds <input type="checkbox"/> Congen Anom <input type="checkbox"/> Trauma <input type="checkbox"/> Other _____	UPPER EXTREMITY (Circle R/L/BOTH) <input type="checkbox"/> Clavicle R / L <input type="checkbox"/> AC Joints R / L <input type="checkbox"/> Shoulder R / L <input type="checkbox"/> Humerus R / L <input type="checkbox"/> Elbow R / L <input type="checkbox"/> Forearm R / L <input type="checkbox"/> Wrist R / L <input type="checkbox"/> Hand R / L <input type="checkbox"/> Finger(s) R / L <input type="checkbox"/> Scapula R / L <input type="checkbox"/> Other _____	LOWER EXTREMITY (Circle R/L/BOTH) <input type="checkbox"/> Hip R / L <input type="checkbox"/> Femur R / L <input type="checkbox"/> Femoral Align (MCHC only) <input type="checkbox"/> Knee R / L <input type="checkbox"/> Tibia - Fibula R / L <input type="checkbox"/> Ankle R / L <input type="checkbox"/> Foot R / L <input type="checkbox"/> Heel R / L <input type="checkbox"/> Toe(s) R / L SPINE / PELVIS <input type="checkbox"/> Pelvis <input type="checkbox"/> SI Joints <input type="checkbox"/> Sacrum-Coccyx <input type="checkbox"/> Postural Study	<input type="checkbox"/> Spine Cervical Complete <input type="checkbox"/> Cervical 1 View <input type="checkbox"/> Cervical AP / LAT <input type="checkbox"/> Cervical LAT / FLEX / EXT <input type="checkbox"/> Cervical AP / LAT / FLEX / EXT <input type="checkbox"/> Spine Complete AP / LAT <input type="checkbox"/> Lumbar Complete <input type="checkbox"/> Lumbar 2V <input type="checkbox"/> Lumbar AP / LAT / FLEX / EXT <input type="checkbox"/> Lumbar LAT / FLEX / EXT <input type="checkbox"/> Spine Thoracic <input type="checkbox"/> Scoliosis Standing (MCHC, CAD, GRY, Manistee)
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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. <input type="checkbox"/> Do Not give IV contrast _____ (indicate reason) Most Recent Weight: _____ No Yes <input type="checkbox"/> <input type="checkbox"/> Prior contrast reaction If yes, need steroid prep prior to scan <input type="checkbox"/> <input type="checkbox"/> Current treatment for acute asthma If yes, need steroid prep prior to scan <input type="checkbox"/> <input type="checkbox"/> Known renal insufficiency Most recent GFR level: _____ date: _____ <input type="checkbox"/> Sinus <input type="checkbox"/> Head <input type="checkbox"/> Neck Spine: <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Chest _____ <input type="checkbox"/> Cardiac <input type="checkbox"/> Abdomen (Diaphragm to iliac crest) <input type="checkbox"/> Abdomen & Pelvis <input type="checkbox"/> Pelvis <input type="checkbox"/> Upper Extremity ___ L ___ R <input type="checkbox"/> Lower Extremity ___ L ___ R <input type="checkbox"/> CT Special Procedures <input type="checkbox"/> CTA _____ <input type="checkbox"/> CT other: _____ GASTROINTESTINAL <input type="checkbox"/> Esophagram <input type="checkbox"/> Sialogram <input type="checkbox"/> Video Fluoro <input type="checkbox"/> Sniff Test <input type="checkbox"/> Upper GI <input type="checkbox"/> Small Bowel	(CONT. GASTROINTESTINAL) <input style="color: red;" type="checkbox"/> Barium Enema <input style="color: red;" type="checkbox"/> Defecography <input style="color: red;" type="checkbox"/> Other _____ GENITOURINARY <input type="checkbox"/> Cystogram <input type="checkbox"/> Voiding Cystourethrogram <input type="checkbox"/> Hysterosalpingogram <input type="checkbox"/> Other _____ INTERVENTIONAL RADIOLOGY <input type="checkbox"/> Perm Cath Removal <input type="checkbox"/> Perm Cath Insertion <input type="checkbox"/> Other Interventional Procedures at MMC <input type="checkbox"/> Other _____ BREAST IMAGING <input type="checkbox"/> Bone Densitometry <input style="color: red;" type="checkbox"/> Mammogram <input style="color: red;" type="checkbox"/> Screening <input type="checkbox"/> Diagnostic ___ Unilateral ___ L ___ R ___ Bilateral <input type="checkbox"/> Ultrasound Breast ___ Unilateral ___ L ___ R ___ Bilateral <input type="checkbox"/> Screening Whole Breast Ultrasound <input style="color: red;" type="checkbox"/> Cyst Aspiration <input style="color: red;" type="checkbox"/> Needle Loc <input style="color: red;" type="checkbox"/> Stereotactic Biopsy <input style="color: red;" type="checkbox"/> Core Biopsy <input type="checkbox"/> Other _____ MISCELLANEOUS <input type="checkbox"/> Arthrogram <input type="checkbox"/> Shoulder ___ L ___ R <input type="checkbox"/> Hip ___ L ___ R <input type="checkbox"/> Other _____	MRI / MRA I.V. Contrast will be prescribed based on clinical indications and information. Head: <input type="checkbox"/> Brain <input type="checkbox"/> Orbits <input type="checkbox"/> Sella <input type="checkbox"/> IAC <input type="checkbox"/> Neck Soft Tissue Spine: <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Chest <input type="checkbox"/> Heart <input type="checkbox"/> Breast <input type="checkbox"/> Abdomen specify: _____ <input type="checkbox"/> Pelvis Musculoskeletal Joint Upper Extremity ___ L ___ R Lower Extremity ___ L ___ R ___ with X-ray Arthrogram <input type="checkbox"/> Upper Extremity ___ L ___ R <input type="checkbox"/> Lower Extremity ___ L ___ R <input style="color: red;" type="checkbox"/> MRI with Anesthesia <input type="checkbox"/> MRI w/o Anesthesia (need H&P within 30 days of apt.) <input type="checkbox"/> MRA _____ <input type="checkbox"/> MRV _____ <input type="checkbox"/> Other _____ MYELOGRAM <input type="checkbox"/> Cervical (with CT) <input type="checkbox"/> Thoracic (with CT) <input type="checkbox"/> Lumbar (with CT) <input type="checkbox"/> Complete (with CT) <input style="color: red;" type="checkbox"/> Discogram <input type="checkbox"/> Other _____ ULTRASOUND / VASCULAR LAB use Ultrasound Order Form #10413	NUCLEAR MEDICINE <input style="color: red;" type="checkbox"/> MYO MULTI SPECT W/STRESS <input type="checkbox"/> MYO MULTI Pharmacologic <input type="checkbox"/> Lexiscan <input type="checkbox"/> Adenosine <input type="checkbox"/> Dobutamine <input type="checkbox"/> Bone Scan <input type="checkbox"/> 3phase <input type="checkbox"/> SPECT <input type="checkbox"/> Whole body (cancer protocol) <input type="checkbox"/> White Blood Cells <input type="checkbox"/> w/SPECT <input type="checkbox"/> MIBG Scan <input type="checkbox"/> w/SPECT <input type="checkbox"/> NM Octreoscan <input type="checkbox"/> w/SPECT <input type="checkbox"/> Parathyroid Imaging <input type="checkbox"/> w/SPECT <input type="checkbox"/> Pulm Perfusion / Aerosal / Ventilation (VQ) <input type="checkbox"/> Pulm Perfusion / Ventilation Quantitative <input type="checkbox"/> Bowel Imaging <input type="checkbox"/> Meckels <input type="checkbox"/> GI Bleed <input type="checkbox"/> Brain w/SPECT(Datscan) <input style="color: red;" type="checkbox"/> Gallbladder Imaging <input type="checkbox"/> w/stimulation <input type="checkbox"/> Cardiac Blood Pool (MUGA) <input style="color: red;" type="checkbox"/> Gastric Emptying <input type="checkbox"/> Solid <input type="checkbox"/> Liquid <input type="checkbox"/> Liquid/Solid <input style="color: red;" type="checkbox"/> I ¹³¹ Total Body Scan <input type="checkbox"/> w/treatment <input type="checkbox"/> w/retention + treatment <input type="checkbox"/> w/thyrogen <input type="checkbox"/> w/thyrogen + treatment <input type="checkbox"/> I ¹³¹ Therapy <input type="checkbox"/> Hyperthyroid <input type="checkbox"/> Cancer, Thyroid <input style="color: red;" type="checkbox"/> Thyroid + Uptake <input type="checkbox"/> Lymph Gland Imaging (Sentinel Node) <input type="checkbox"/> Renal w/Flow + diuretic PET SCAN-use PET SCAN Order Form #6532 Other _____
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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

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|--|---|
| <input type="checkbox"/> KALKASKA MEMORIAL HEALTH CENTER (KMHC) | <input type="checkbox"/> MUNSON MEDICAL CENTER (MMC - Main Lobby) |
| <input type="checkbox"/> MUNSON COMMUNITY HEALTH CENTER (MCHC) | <input type="checkbox"/> MUNSON PROFESSIONAL BLDG (MPB) |
| <input type="checkbox"/> MUNSON HEALTHCARE CADILLAC HOSPITAL (CAD) | <input type="checkbox"/> PAUL OLIVER MEMORIAL HOSPITAL (POMH) |
| <input type="checkbox"/> MUNSON HEALTHCARE GRAYLING HOSPITAL (GRY) | <input type="checkbox"/> SMITH FAMILY BREAST HEALTH CENTER |
| <input type="checkbox"/> Roscommon | <input type="checkbox"/> Prudenville |

- ELK RAPIDS CLINIC **231-264-0025**
- INTERVENTIONAL RADIOLOGY (MMC - Main Lobby)
Phone: 231-935-2861 Fax: 231-935-2862
- KINGSLEY CLINIC **231-392-7892**

**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:**
- Nothing to eat or drink 3 hours prior to exam.
 - Esophagram studies usually take less than 1 hour.
- UPPER GI / SMALL BOWEL STUDIES:**
- Light supper on the day prior to the exam.
 - Nothing to eat or drink (including water) after 9:00 p.m. prior to exam.
 - Upper GI studies usually take less than 1 hour.
 - 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 I¹²³ 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.
- I¹³¹ 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:**
- Castor oil, 1-1/2 ounces, or one 10 ounce bottle of magnesium citrate at 7:00 p.m. on the evening prior to the examination.
 - 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.