Patient Label

NORTHWESTERN MEDICAL CENTER DIAGNOSTIC IMAGING ORDER FORM

*** IF YOU HAVE ANY QUESTIONS OR CONCERNS, PLEASE CALL US AT 802-524-1058 ***

ORDERING PHYSICIAN: ____________________ ROUTINE STAT

SIGNATURE: ____________________ DATE OF ORDER: __________

PHYSICIAN PHONE/PAGER: ____________________

PATIENT NAME: ____________________ DOB: __________

PATIENT CONTACT INFORMATION/PHONE: ____________________

INSURANCE: ______________ PA/AUC #: ______________

------------ * REQUIRED ORDER INFORMATION (ALL EXAMS) * ------------

EXACT ANATOMICAL AREA OF INTEREST: ____________________

SIGNS, SYMPTOMS, REASON FOR EXAM:

____

PREVIOUS IMAGING OF AREA OF INTEREST? YES ____ NO ____ UNKNOWN ___ WHERE__________

HEIGHT: __________ WEIGHT: __________ SPECIAL NEEDS: ______________

GLUCOSE MONTIORING DEVICE? YES _____ NO ______ (If yes, patient may need to remove it prior to exam.)

ANY CHANCE OF PREGNANCY? YES _____ NO ______ (If yes, may need to consult with Radiologist.)

------------ APPOINTMENTS REQUIRED FOR ALL EXAMS ------------

MRI (Specify) ____________________ W _____ W/O _____ W/WO _____

ARTHROGRAM (Specify) SHOULDER _____ HIP_____ WRIST _____ RIGHT _____ LEFT _____

CT SCAN ____________________ W _____ W/O _____ W/WO _____

*****FOR CT LOW DOSE LUNG SCREENING, PLEASE UTILIIZE DEDICATED LDCT ORDER*****

***** FOR ALL BREAST IMAGING (MAMMO & U/S), PLEASE UTILIZE DEDICATED BREAST IMAGING ORDER*****

ULTRASOUND (Specify) ____________________

DVT__________ Upper/Lower_______ Right/Left________ call-back # for results: __________

NUCLEAR MEDICINE (Specify) Bone scan, HIDA scan, etc. ____________________

NUCLEAR MEDICINE CARDIAC STRESS TEST (Specify which) Pharmacological (No Exercise) _____EXERCISE _______

Exercise Stress Test (ETT)__________

FLUOROSCOPY STUDY (Specify) ESOPHAGRAM/BASW______ UGI ______ SBFT ______ BE, W/ AIR ______

MODIFIED BARIUM SWALLOW (MBASW) _____ *Must be scheduled with Speech Therapy*

HYSTEROSALPINGOGRAM_______ *Must be scheduled with OB/GYN provider*

BONE DENSITY (Specify) WHOLE BODY/AXIAL_______ APPENDICULAR/WRIST (IF NEEDED w/ AXIAL) _______

XRAY EXAM (Specify) ____________________ RIGHT _____ LEFT _____

OTHER STUDY NOT LISTED (Specify) ____________________

------------ REQUIRED INFORMATION FOR CONTRAST STUDIES ------------

CURRENT MEDICATIONS: ____________________

ALLERGIES (Specify): ____________________

CONTRAST ALLERGY? (Specify) IODINE/CT/IVP CONTRAST _____ MRI CONTRAST _____

**If allergic to contrast, patient MUST be pre-medicated 13hrs prior. Please call to verify protocol.*

IS THE PATIENT AT RISK FOR RENAL INSUFFICIENCY? (i.e., over age 60, diabetic, on hypertensive medication, known kidney disease, etc.) YES________ NO________ (If yes, must have labs done within 60 days prior to their exam.)

DATE LABS DRAWN: ______________ CREATININE: _______ GFR:________