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:________