

# New Radiology Order Form

**Memorial**  
Hospital of South Bend  
413 E. Michigan St. • South Bend, Indiana 46601

To schedule please call 574-647-7700  
Please fax this side only to 574-647-2200  
\* Exams Requiring Special Preparation  
(see back)

Place Label Here

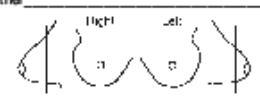
Patient Name

Date of Birth

Diagnosis

Procedure

Physician Signature

Patient Name (Last, First) _____		DOB _____	Ordering Physician _____
Clinical History/DX _____		ICD9 Code _____	
Pre-Authorization # _____ Insurance Co. _____			
Appointment Date _____ Time _____ Pt. Phone # _____			
<input type="checkbox"/> Hospital <input type="checkbox"/> Navarre - #5510 <input type="checkbox"/> Lighthouse <input type="checkbox"/> To schedule an MRI call 574-272-9991 or 888-272-9991			
<input type="checkbox"/> View via PACS <input type="checkbox"/> Report only to office <input type="checkbox"/> Film with report to office <input type="checkbox"/> CD with report to office <input type="checkbox"/> Patient to hand carry films			
<b>Hold and Call Report</b> Call Report # _____ Fax Report _____			
<b>CT/CTA</b> <input type="checkbox"/> Brain <input type="checkbox"/> CTA Brain <input type="checkbox"/> Sinuses <input type="checkbox"/> CTA Abd/LE Runoff <input type="checkbox"/> Temporal Bones/IAC <input type="checkbox"/> Carotids <input type="checkbox"/> Orbits <input type="checkbox"/> Aorta-Thoracic <input type="checkbox"/> Chest <input type="checkbox"/> Aorta-Abdominal <input type="checkbox"/> Chest for PE <input type="checkbox"/> CTA Renals <input type="checkbox"/> Abdomen & Pelvis <input type="checkbox"/> Cardiac Scoring <input type="checkbox"/> Abdomen Only <input type="checkbox"/> CTA Coronary <input type="checkbox"/> Pelvis Only <input type="checkbox"/> CTA Upper Extremity <input type="checkbox"/> Neck Soft Tissue <input type="checkbox"/> Specify _____ <input type="checkbox"/> Renal/Adrenals <input type="checkbox"/> Specify _____ <input type="checkbox"/> Renal Stone <input type="checkbox"/> Specify _____ <input type="checkbox"/> CT Cystogram <input type="checkbox"/> Specify _____ <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Specify _____ <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Specify _____ <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Specify _____ <input type="checkbox"/> Facial Bones <input type="checkbox"/> Specify _____ <input type="checkbox"/> Extremity: Specify _____ <input type="checkbox"/> CT Arthrogram: Specify _____		<b>ULTRASOUND</b> <input type="checkbox"/> Gallbladder/Liver (RUQ) <sup>8</sup> <input type="checkbox"/> Abdomen Complete <sup>8</sup> <input type="checkbox"/> Renal/Kidney (includes bladder) <sup>7</sup> <input type="checkbox"/> Aorta <sup>8</sup> <input type="checkbox"/> Early OB (less than 14 weeks) <sup>8</sup> <input type="checkbox"/> OB (greater than 14 weeks) <sup>8</sup> <input type="checkbox"/> OB Limited (AFI only or Cervical length only) <sup>8</sup> <input type="checkbox"/> Biophysical Profile <input type="checkbox"/> Pelvic (w/ Endovaginal if indicated) <sup>8</sup> <input type="checkbox"/> Endovaginal only <input type="checkbox"/> Follicle study <input type="checkbox"/> Sonohysterogram <input type="checkbox"/> Thyroid/Neck <input type="checkbox"/> Thyroid Biopsy <input type="checkbox"/> Testicular/Scrotum <input type="checkbox"/> Carotid <input type="checkbox"/> Extremity: Venous Doppler <input type="checkbox"/> Left <input type="checkbox"/> Right / <input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Other _____	
<b>NUCLEAR MEDICINE</b> Bone Scan: <input type="checkbox"/> Whole Body <input type="checkbox"/> Multiple specific area <input type="checkbox"/> 3-phase <input type="checkbox"/> SPECT <input type="checkbox"/> Liver/Spleen Scan <input type="checkbox"/> RBC Liver Hemangioma <input type="checkbox"/> Hepatobiliary (HIDA) <sup>2</sup> <input type="checkbox"/> CCK Ejection Fraction: <input type="checkbox"/> with <input type="checkbox"/> without <input type="checkbox"/> Cardiac MUGA Scan <sup>8</sup> <input type="checkbox"/> Nuclear Stress Test (Myocardial Perfusion Imaging) <sup>8</sup> <input type="checkbox"/> Treadmill <input type="checkbox"/> Adenosine/Levixcan <input type="checkbox"/> Dobutamine <input type="checkbox"/> Gastric Empty (Solid) <input type="checkbox"/> GE Reflux Study (Infants) <sup>5</sup> <input type="checkbox"/> Meckel's Scan <sup>5</sup> <input type="checkbox"/> Gallium Scan <input type="checkbox"/> Indium WBC Scan <input type="checkbox"/> Lung Scan Vent/Perfusion <input type="checkbox"/> Quantitative <input type="checkbox"/> Cisternogram <input type="checkbox"/> Octroscan <input type="checkbox"/> Parathyroid Scan <input type="checkbox"/> Thyroid Consultation <input type="checkbox"/> Thyroid Uptake and Scan <sup>8</sup> <input type="checkbox"/> Treatment if indicated <input type="checkbox"/> I-131 Whole Body Scan <sup>5</sup> <input type="checkbox"/> Renal Scan <input type="checkbox"/> Renal scan/Lasix washout <input type="checkbox"/> Renal scan/Captopril <input type="checkbox"/> Other _____		<b>GIGU</b> <input type="checkbox"/> Esophagram <sup>8</sup> <input type="checkbox"/> IV <sup>12</sup> <input type="checkbox"/> Upper GI <sup>9</sup> <input type="checkbox"/> VCIG <input type="checkbox"/> Upper GI/Small Bowel <sup>10</sup> <input type="checkbox"/> Cystogram <input type="checkbox"/> Small Bowel Only <sup>10</sup> <input type="checkbox"/> Hysterosalpingogram <input type="checkbox"/> Swallow Function Study <input type="checkbox"/> Barium Enema <sup>11</sup> <input type="checkbox"/> Air contrast <input type="checkbox"/> Single contrast <input type="checkbox"/> Other _____	
<input type="checkbox"/> Other _____		<b>RADIOGRAPHY</b> <b>HEAD</b> <input type="checkbox"/> Facial Bones <input type="checkbox"/> Sinus <input type="checkbox"/> Nasal Bones <input type="checkbox"/> Skull <b>CHEST</b> <input type="checkbox"/> PA & Lateral <input type="checkbox"/> Ribs <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Sternum <b>ABDOMEN</b> <input type="checkbox"/> Abdominal Series <input type="checkbox"/> Flat/Upright <input type="checkbox"/> KUB <b>SPINE</b> <input type="checkbox"/> Bone Survey <input type="checkbox"/> Scoliosis Study <input type="checkbox"/> Cervical <input type="checkbox"/> AP/Lat <input type="checkbox"/> 4 vws (RTN) <input type="checkbox"/> 6vws (RTN+flex/ext) <input type="checkbox"/> Lumbar <input type="checkbox"/> AP/Lat <input type="checkbox"/> 4 vws (RTN) <input type="checkbox"/> 6vws (RTN+flex/ext) <input type="checkbox"/> Thoracic <input type="checkbox"/> Sacrum & Coccyx	
<input type="checkbox"/> Other _____		<b>EXTREMITIES/PELVIS</b> <input type="checkbox"/> Fingers: Spec. <input type="checkbox"/> Hand <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Wrist <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Forearm <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Elbow <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Humerus <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> AC Joints BL w/wo wts. <input type="checkbox"/> Clavicle <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Shoulder <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Toes: Spec. <input type="checkbox"/> Foot <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Calcaneous <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Ankle <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Tibia/Fibia <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Knee <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Standing Knees <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Femur <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Hip <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Pelvis <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Other _____	
<input type="checkbox"/> Other _____		<b>LABORATORY</b> <input type="checkbox"/> BUN <input type="checkbox"/> Creatinine <input type="checkbox"/> PT <input type="checkbox"/> PTT <input type="checkbox"/> INR <input type="checkbox"/> CBC w/differential <input type="checkbox"/> Other _____	
<input type="checkbox"/> Other _____		<b>MAMMOGRAM &amp; BREAST DIAGNOSTICS<sup>13</sup></b> <input type="checkbox"/> Screening Mammo <input type="checkbox"/> Diagnostic Bilateral Mammo (w/ Ultrasound if ind.) <input type="checkbox"/> Unilateral Mammo (w/ Ultrasound if indicated) <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Image Guided Breast Biopsy <input type="checkbox"/> Cyst Aspiration <input type="checkbox"/> Breast Ultrasound <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Other _____	
<input type="checkbox"/> Other _____			
<input type="checkbox"/> Other _____		<b>BONE DENSITY STUDY (DEXA)</b> <input type="checkbox"/> Osteoporosis Scan (Lighthouse location only) Special Instructions: _____	
Physician Signature _____		Date _____	

Page 1 of 1 Reorder from Materials  
Form # 576181 Address 576181 MC  
**RADIOLOGY IMAGING SERVICES**



**A valid order must be legible and include:**

- Patient Name
- Date of Birth
- Diagnosis
- Procedure
- Physician Signature (a stamp or nurse signature *is not acceptable* per Medicare regulations)