

Memorial

Hospital of South Bend*

615 N. 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 IDENTIFICATION

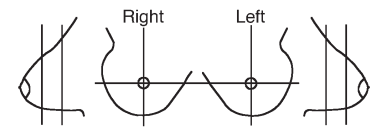
Patient Name (Last) _____ (First) _____ DOB _____ Ordering Physician _____
CC _____ Comments _____
Clinical History/DX _____ ICD9 Code _____
Pre-Authorization # _____ Insurance Co. _____
Appointment Date _____ Time _____ Pt. Phone # _____
 Hospital Navarre - #5510 Lighthouse To schedule an MRI call 574-272-9991 or 888-272-9991

View via PACS Report only to office Film with report to office CD with report to office Patient to hand carry films
Hold and Call Report Call Report # _____ Fax Report _____

w ¹ w/o	CT/CTA	ULTRASOUND	RADIOGRAPHY (continued)
<input type="checkbox"/> Brain <input type="checkbox"/> Sinuses <input type="checkbox"/> Temporal Bones/IAC <input type="checkbox"/> Orbits <input type="checkbox"/> Chest <input type="checkbox"/> Chest for PE <input type="checkbox"/> Abdomen & Pelvis <input type="checkbox"/> Abdomen Only <input type="checkbox"/> Pelvis Only <input type="checkbox"/> Neck Soft Tissue <input type="checkbox"/> Renal/Adrenals <input type="checkbox"/> Renal Stone <input type="checkbox"/> CT Cystogram <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Facial Bones <input type="checkbox"/> Extremity: Specify _____ <input type="checkbox"/> CT Arthrogram: Specify _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> CTA Brain <input type="checkbox"/> CTA Abd/LE Runoff <input type="checkbox"/> Carotids <input type="checkbox"/> Aorta-Thoracic <input type="checkbox"/> Aorta-Abdominal <input type="checkbox"/> CTA Renals <input type="checkbox"/> Cardiac Scoring <input type="checkbox"/> CTA Coronary <input type="checkbox"/> CTA Upper Extremity Specify _____	<input type="checkbox"/> Gallbladder/Liver (RUQ) ⁶ <input type="checkbox"/> Abdomen Complete ⁶ <input type="checkbox"/> Renal/Kidney (includes bladder) ⁷ <input type="checkbox"/> Aorta ⁶ <input type="checkbox"/> Early OB (less than 14 weeks) ⁸ <input type="checkbox"/> OB (greater than 14 weeks) ⁸ <input type="checkbox"/> OB Limited (AFI only or Cervical length only) ⁸ <input type="checkbox"/> Biophysical Profile <input type="checkbox"/> Pelvic (w/ Endovaginal if indicated) ⁸ <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 _____	EXTREMITIES/PELVIS <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"/> Other _____

NUCLEAR MEDICINE	GI/GU	LABORATORY
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) ² CCK Ejection Fraction: <input type="checkbox"/> with <input type="checkbox"/> without <input type="checkbox"/> Cardiac MUGA Scan ³ Nuclear Stress Test (Myocardial Perfusion Imaging) ⁴ <input type="checkbox"/> Treadmill <input type="checkbox"/> Adenosine/Lexiscan <input type="checkbox"/> Dobutamine <input type="checkbox"/> Gastric Empty (Solid) ⁵ <input type="checkbox"/> GE Reflux Study (infants) ⁵ <input type="checkbox"/> Meckel's Scan ⁵ <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"/> Octreoscan <input type="checkbox"/> Parathyroid Scan <input type="checkbox"/> Thyroid Consultation <input type="checkbox"/> Thyroid Uptake and Scan ⁵ <input type="checkbox"/> Treatment if indicated <input type="checkbox"/> I-131 Whole Body Scan ⁵ <input type="checkbox"/> Renal Scan <input type="checkbox"/> Renal scan/Lasix washout <input type="checkbox"/> Renal scan/Captopril <input type="checkbox"/> Other _____	<input type="checkbox"/> Esophagram ⁹ <input type="checkbox"/> Upper GI ⁹ <input type="checkbox"/> Upper GI/Small Bowel ¹⁰ <input type="checkbox"/> Small Bowel Only ¹⁰ <input type="checkbox"/> Swallow Function Study <input type="checkbox"/> Barium Enema ¹¹ <input type="checkbox"/> Air contrast <input type="checkbox"/> Single contrast <input type="checkbox"/> Other _____ <input type="checkbox"/> IVP ¹² <input type="checkbox"/> VCUG <input type="checkbox"/> Cystogram <input type="checkbox"/> Hysterosalpingogram	<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 _____

RADIOGRAPHY	MAMMOGRAM & BREAST DIAGNOSTICS ¹³
HEAD <input type="checkbox"/> Facial Bones <input type="checkbox"/> Sinus <input type="checkbox"/> Nasal Bones <input type="checkbox"/> Skull CHEST <input type="checkbox"/> PA & Lateral <input type="checkbox"/> Ribs <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Sternum ABDOMEN <input type="checkbox"/> Abdominal Series <input type="checkbox"/> Flat/Upright <input type="checkbox"/> KUB SPINE <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"/> 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 _____



BONE DENSITY STUDY (DEXA)
<input type="checkbox"/> Osteoporosis Scan (Lighthouse location only) Special Instructions: _____

Physician Signature _____ Date _____

