CookChildren's

# Radiology orders

**4100 W. University Dr., Prosper TX 75078**

☐ Send CD with patient

**Please call 945-204-1650 to schedule diagnostic, ultrasound, CT and MRI exams.**
**Fax the completed form to 945-204-9541.**

* All fields marked with an asterisk MUST be completed. Prior authorization needed before appointment.

* Patient name: _____ * Date of birth: _____ Gender: _____

* Symptoms / reason for exam / diagnosis: _____

**General anesthesia needed:** ☐ Yes ☐ No

If yes, complete the following:

Renal disease ☐ Yes ☐ No

Cardiac issues ☐ Yes ☐ No
(defects, surgeries, implanted devices, etc.)

Respiratory issues ☐ Yes ☐ No
(apnea, OSA, uncontrolled asthma, tracheostomy/vent/difficult airway, etc.)

Emotional/Behavioral condition ☐ Yes ☐ No
Type and severity _____

Implanted device ☐ Yes ☐ No
Device _____

* Ordering provider (print name): _____

* Phone (needed for order clarification): _____ * Fax: _____

## Diagnostic

### Chest:
☐ PA/LAT ☐ AP only ☐ Sternum
Decubitus: ☐ L ☐ R ☐ B
Ribs: ☐ B

### Abdomen:
☐ KUB ☐ KUB with upright
☐ Left lateral decubitus

### Head:
Skull: ☐ 2 view ☐ 4 view
☐ Sinuses ☐ Facial bones
☐ Nasal bones

### Spine:
☐ Cervical ☐ Flex/Ext
☐ Thoracic
☐ Lumbar
☐ Scoliosis ☐ AP ☐ AP/LAT
☐ Sacrum/Coccyx

### Pelvis:
☐ AP/Frog leg ☐ SI joints

### Upper extremity:
Clavicle ☐ L ☐ R
Shoulder ☐ L ☐ R
Humerus ☐ L ☐ R
Elbow ☐ L ☐ R
Forearm ☐ L ☐ R
Wrist ☐ L ☐ R
Hand ☐ L ☐ R
Fingers ☐ L ☐ R Digit: ____

### Lower extremity:
Femur ☐ L ☐ R
Knee ☐ L ☐ R
Tibia/Fibula ☐ L ☐ R
Ankle ☐ L ☐ R
Foot ☐ L ☐ R
Heel ☐ L ☐ R
Toes ☐ L ☐ R Digit: ____

### Miscellaneous:
☐ Bone age ☐ Neck soft tissue
☐ Leg length ☐ Skeletal survey
☐ Other _____

## Ultrasound

☐ Head
☐ Abdomen ☐ Complete ☐ Limited ☐ Doppler
☐ Gallbladder
☐ Liver
☐ Soft tissue _____
☐ Breast ☐ L ☐ R
☐ Pelvic
☐ Spine
☐ Renal ☐ Doppler
☐ Testicular
☐ Thyroid
☐ Chest
☐ Hip ☐ Dynamic ☐ Limited
☐ Extremity _____ ☐ L ☐ R ☐ Doppler ☐ Venous ☐ Arterial
☐ Other _____

## CT

☐ Head
☐ Temporal bones
☐ Face ☐ Orbits ☐ Sinuses
☐ Neck soft tissue
Spine: ☐ Cervical ☐ Thoracic ☐ Lumbar
☐ Chest/Abdomen/Pelvis
☐ Chest
☐ Abdomen/Pelvis
☐ Pelvis
☐ Extremity _____ ☐ L ☐ R
☐ CTA _____
☐ Other _____

☐ IV contrast ☐ Yes ☐ No
☐ Oral contrast ☐ Yes ☐ No
☐ At radiologist's discretion

## Fluoroscopy

☐ Esophagram
☐ Upper GI ☐ With small bowel
☐ Small bowel only
☐ Barrium enema
☐ VCUG
☐ IVP
☐ Other _____

## MRI

☐ Angiography
☐ Internal auditory canal (middle ear)
☐ Brain ☐ Rapid
☐ Brain with spectroscopy
☐ Pituitary
☐ Cervical spine
☐ Thoracic spine
☐ Lumbar spine
☐ Complete spine
☐ Orbits, face and neck
☐ Chest
☐ Abdomen
☐ Pelvis
☐ Hip ☐ L ☐ R ☐ Arthrogram
☐ Shoulder ☐ L ☐ R ☐ Arthrogram
☐ Elbow ☐ L ☐ R ☐ Arthrogram
☐ Wrist ☐ L ☐ R ☐ Arthrogram
☐ Femur ☐ L ☐ R
☐ Knee ☐ L ☐ R ☐ Arthrogram
☐ Tibia/Fibula ☐ L ☐ R
☐ Ankle ☐ L ☐ R ☐ Arthrogram
☐ Foot ☐ L ☐ R
☐ MRCP
☐ Enterography
☐ Liver/Elastography
☐ Other _____

Contrast for MRI
☐ Without ☐ With ☐ With and without
☐ At radiologist's discretion

☐ Any additional imaging or IV contrast needed per radiologist's discretion

***Instructions:** ☐ Release patient ☐ Hold patient ☐ Patient to return to office
☐ Call report to phone # _____

Physician signature : _____ Date: _____