

McLaren Print System Order

Order No: 47595
 Order Date: 2019-08-08
 User: Jodi Peterman
 Phone: 3422133

Ship Location: Jodi Peterman - McLaren Flint MRI Ballenger
 750 S Ballenger Hwy
 Flint, MI 48532

Forms
 Quantity: 25
 Paragon Dept No: 32113
 Dept Name: McLaren Flint MRI Ballenger
 Company Number: 60

Order Total Price: 327.50

Item Number: M-22016-B
 Item Description: Imaging Center Order Form
 Revision Date: 5/2018
 Print:
 Paper:
 Size:
 Fold:
 Finish:
 Drill:
 Misc Info: ds; full color; 50 Sheets per pad. Please order how many pads you would like. BW

McLaren FLINT		OUTPATIENT RADIOLOGY ORDER FORM		Appointment Date _____	Appointment Time _____	
(OPTIONAL) WEST 75000 McLaren Imaging Center • Ph: 810.342.4800 Fax: 810.342.4808 McLaren MRI Ballenger Hwy • Ph: 810.226.8010 Fax: 810.226.8018						
Patient Name _____ DOB _____ Height _____ Weight _____						
INSTITUTION PHONE _____						
INSURANCE _____ PMS AUTHORIZATION NUMBER _____						
DIAGNOSIS/REASON FOR EXAM (PLEASE INCLUDE LATERALITY, SPECIFIC SITE)						
ORDERING PROVIDER (PRINT NAME) _____		OFFICE CONTACT _____				
MRI	<input type="checkbox"/> GREY <input type="checkbox"/> T1W <input type="checkbox"/> T2W	<input type="checkbox"/> INITIAL STAGING <input type="checkbox"/> BRILL TO WHO PHASE <input type="checkbox"/> ANGIOGRAPHIC VIABILITY <input type="checkbox"/> EARLY BONE SCANS	<input type="checkbox"/> SUBSEQUENT <input type="checkbox"/> BRILL TO WHO PHASE <input type="checkbox"/> BRILL TO WHO PHASE <input type="checkbox"/> BRILL TO WHO PHASE			
	<input type="checkbox"/> FLUOROSCOPY <input type="checkbox"/> SINGLE SWALLOW <input type="checkbox"/> UG <input type="checkbox"/> SB <input type="checkbox"/> SE <input type="checkbox"/> CHYSTOGRAM <input type="checkbox"/> OTHER					
US	<input type="checkbox"/> PELVIC (WITH TRANS VAG IF NECESSARY) <input type="checkbox"/> ABDOMEN <input type="checkbox"/> OB/GYN		<input type="checkbox"/> TESTICLES (WITH COLOR FLOW IF NECESSARY) <input type="checkbox"/> BLADDER <input type="checkbox"/> BREAST FOUNDATION <input type="checkbox"/> RENAL ARTERY		<input type="checkbox"/> RENAL/KIDNEY <input type="checkbox"/> THYROID <input type="checkbox"/> BREAST <input type="checkbox"/> CAROTID <input type="checkbox"/> ARTERIAL (COLORFLOW IF NECESSARY) <input type="checkbox"/> OTHER	
	<input type="checkbox"/> COLOR DOPPLER: <input type="checkbox"/> NORTH <input type="checkbox"/> VENOUS <input type="checkbox"/> OTHER					
CT	<input type="checkbox"/> HEAD <input type="checkbox"/> CHEST <input type="checkbox"/> PELVIS <input type="checkbox"/> C-SPINE <input type="checkbox"/> NORTH <input type="checkbox"/> ROOMEN <input type="checkbox"/> ROOMEN/PELVIS		<input type="checkbox"/> EXTREMITY <input type="checkbox"/> HEAD			
	<input type="checkbox"/> SOFT TISSUE NECK <input type="checkbox"/> HIGH-RES CHEST <input type="checkbox"/> ABDOMEN <input type="checkbox"/> RENAL STONE <input type="checkbox"/> L-SPINE <input type="checkbox"/> UPPER <input type="checkbox"/> LOWER <input type="checkbox"/> L-SPINE					
SCLER	<input type="checkbox"/> 3 PHASE BONE (WITH TOTAL BODY IF NECESSARY) <input type="checkbox"/> TOTAL BONE BODY (WITH 3 PHASE IF NECESSARY)		<input type="checkbox"/> L-SPINE <input type="checkbox"/> R-SPINE <input type="checkbox"/> L-SPINE <input type="checkbox"/> R-SPINE			
	<input type="checkbox"/> WIS BONE <input type="checkbox"/> MESA <input type="checkbox"/> RENAL (WITH/LAB) <input type="checkbox"/> RENAL (WITHOUT LAB) <input type="checkbox"/> OTHER					
MAMM	<input type="checkbox"/> MAMMOGRAPHY (with no description or problem being previous mammogram) <input type="checkbox"/> AD SCREENING <input type="checkbox"/> BI SCREENING					
	<input type="checkbox"/> WITH ULTRASOUND IF NEEDED <input type="checkbox"/> BILATERAL <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT					
<input type="checkbox"/> LUMP PAIR THICKENING <input type="checkbox"/> SIMPLE D/C <input type="checkbox"/> ABNORMAL MAMM <input type="checkbox"/> OTHER						
<input type="checkbox"/> BONE DENSITOMETRY <input type="checkbox"/> L-SPINE/R-SPINE						
PROCEDURE		<input type="checkbox"/> EYE/OPHTHALM <input type="checkbox"/> SALICITURAM <input type="checkbox"/> LUMBAL PUNCTURE <input type="checkbox"/> ANTHROGRAM				
<input type="checkbox"/> BREAST EX <input type="checkbox"/> STEREO <input type="checkbox"/> US-GONE <input type="checkbox"/> HYSTEROSALPINGOGRAM <input type="checkbox"/> ARTHROGRAM		<input type="checkbox"/> MISC/GRAM <input type="checkbox"/> NEEDLE ASP. EX <input type="checkbox"/> PAIN MANAGEMENT				
<input type="checkbox"/> TELEPHONE REPORT (Please Patient) _____		PROVIDER Signature _____ Signature Errors are NOT valid				
<input type="checkbox"/> TELEPHONE REPORT (Please Patient) _____		Date _____ Time _____				
Contract with order is necessary to optimize the diagnostic capability of the exam. Additional studies will be performed as clinically necessary to optimize the diagnostic quality of the study that is being performed (e.g., a hip for an abnormal knee exam). Signing this form indicates your agreement of the above.						

Spec Info:

