

McLaren Print System Order

Order No: 48075
Order Date: 2019-08-28
User: Jennifer Dixon
Phone: 810.342.2138

Ship Location: MIC/Jennifer Dixon
501 S Ballenger Hwy , Suite B
Flint, MI 48532

Forms
Quantity: 25
Paragon Dept No: 32011
Dept Name: McLaren Imaging Center
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 _____

McLaren Imaging Center • Ph: 810.342.4800 Fax: 810.342.4808
McLaren MIC Ballenger Hwy • Ph: 810.226.8010 Fax: 810.226.8018

Patient Name _____ DOB _____ Height _____ Weight _____

REFERRAL INFORMATION
 REFERRING PHYSICIAN _____
 REFERRAL PHONE _____
 INSURANCE _____ PMS AUTHORIZATION NUMBER _____
 DIAGNOSIS/REASON FOR EXAM (PLEASE INCLUDE LATERALITY, SPECIFIC SITE) _____
 ORDERING PROVIDER (PRINT NAME) _____ OFFICE CONTACT _____

MR
 MRI _____
 MRA _____
 MRF _____

PT
 INITIAL STAGING SUBSEQUENT
 BRILL TO WHO FRIGID BRILL TO WHO (MELANOMA)
 METASTASIS VIABILITY BRAIN ANGIOGRAPHY/EMBOLIZATION
 BMT BONE SCANS GALLIUM-67 OR SCANDIUM

X-RAY
 FLUOROSCOPY SINGLE SWALLOW LUD SB SE SE - See Back of Order for Page
 NEED ESCAN HP VQAS CHSTOGRAM

US
 PELVIC (WITH TRANS VAG IF NECESSARY) TESTICLES (WITH COLOR FLOW IF NECESSARY) RENAL/KIDNEY
 ABDOMEN OB/GYN BLADDER BREAST FOUNDATION RENAL ARTERY
 PROSTATE THYROID BREAST
 COLOR DOPPLER: NORTH VENOUS CAROTID ARTERIAL (COLORFLOW IF NECESSARY)
 OTHER _____
 EB ESO LESS THAN 10 WKS MORE THAN 10 WKS LIMITED BIOPHYSICAL

CT
 HEAD CHEST PELVIS C-SPINE NORTH ROOMEN ROOMEN/PELVIS
 SOFT TISSUE NECK HIGH-RES CHEST ABDOMEN T-SPINE EXTREMITY HEAD
 SPINE ROOMEN RENAL STONE L-SPINE EXTREMITY UPPER LOWER LR
 OTHER _____ UROGRAM - See Back of Order for Page NORTH BRANCH CHEST OTHER _____

SCANS
 3 PHASE BONE (WITH TOTAL BODY IF NECESSARY)
 TOTAL BONE BODY (WITH 3 PHASE IF NECESSARY)
 T10 SCAN MIBG LEUKOCYTE SCANS - BONE MARROW
 HIDA SCAN RENAL (WITH/LABE) RENAL (WITHOUT LABE) OTHER _____

BIOPSY
 BIOPHYSICAL (with no description or problem being previous mammogram) LD SCREENING SD SCREENING
 WITH ULTRASOUND IF NEEDED BILATERAL LEFT RIGHT
 REASON FOR DIAGNOSTIC STUDY
 LUMP PAIR THICKENING NIPPLE D/C ABNORMAL MAMM OTHER _____
 BONE DENSITOMETRY U.S. SPINE/HP

PROCEDURE
 EYE IMPLICATION SALICITURAM LUMBAL PUNCTURE ANTHROGRAM
 BREAST EX STEREO US-GONE HYSTEROSALPINGOGRAM ARTHROGRAM
 MISCIGRAM NEEDLE ASP. BX PAIN MANAGEMENT OTHER _____

TELEPHONE REPORT (Please Patient) _____ PROVIDER Signature _____ Signature Errors are NOT valid
 TELEPHONE REPORT (Please Patient) _____ Date _____ Date _____

MAKE ORDER FORM 2014 10-12 **6602**

Contract with add-on necessary to optimize the diagnostic capability of the exam. Additional studies will be performed as clinically necessary to optimize the diagnostic capability 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.