

McLaren Print System Order

Order No: 49465
 Order Date: 2019-10-15
 User: Jennifer Dixon
 Phone: 810.342.2138

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

Forms
 Quantity: 50
 Paragon Dept No: 32011
 Dept Name: McLaren Imaging Center
 Company Number: 60

Order Total Price: 655.00

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 75 803E McLaren Imaging Center • Ph: 810.342.4800 Fax: 810.342.4808 McLaren 501 S 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 _____			
MIB	<input type="checkbox"/> CHEST <input type="checkbox"/> CHEST <input type="checkbox"/> CHEST	<input type="checkbox"/> INITIAL STAGING <input type="checkbox"/> BRILL TO WHO FRAGS <input type="checkbox"/> ANGIOGRAPHIC VIABILITY <input type="checkbox"/> NEW BONE SCARS	<input type="checkbox"/> SUBSEQUENT <input type="checkbox"/> BRILL TO WHO FRAGS <input type="checkbox"/> BRILL TO WHO FRAGS <input type="checkbox"/> BRILL TO WHO FRAGS		
	<input type="checkbox"/> FLUOROSCOPY <input type="checkbox"/> BIPHASE BRILL TO WHO FRAGS <input type="checkbox"/> NEED ESCAN GENERAL X-RAY NO APPOINTMENT NEEDED				
US	<input type="checkbox"/> PELVIC (WITH TRANS VAG) IF NECESSARY <input type="checkbox"/> ABDOMEN <input type="checkbox"/> PROSTATE <input type="checkbox"/> COLOR DOPPLER	<input type="checkbox"/> TESTICLES (WITH COLOR FLOW IF NECESSARY) <input type="checkbox"/> BLADDER <input type="checkbox"/> THYROID <input type="checkbox"/> CAROTIDS <input type="checkbox"/> OTHER	<input type="checkbox"/> RENAL/KIDNEY <input type="checkbox"/> RENAL ARTERY <input type="checkbox"/> BREAST FOUNDATION <input type="checkbox"/> BREAST <input type="checkbox"/> ARTERIAL <input type="checkbox"/> COLOR FLOW IF NECESSARY <input type="checkbox"/> OTHER	<input type="checkbox"/> ESOPHAGUS <input type="checkbox"/> LESS THAN 10 WKS <input type="checkbox"/> MORE THAN 10 WKS <input type="checkbox"/> LIMITED <input type="checkbox"/> SONOGRAPHIC	
	<input type="checkbox"/> HEAD <input type="checkbox"/> SOFT TISSUE NECK <input type="checkbox"/> SPINE <input type="checkbox"/> OTHER	<input type="checkbox"/> CHEST <input type="checkbox"/> HIGH-RES CHEST <input type="checkbox"/> ABDOMEN <input type="checkbox"/> UROGRAM	<input type="checkbox"/> PELVIS <input type="checkbox"/> SPINE <input type="checkbox"/> RENAL STONE <input type="checkbox"/> UROGRAM	<input type="checkbox"/> CERVIX <input type="checkbox"/> NORTH <input type="checkbox"/> ROOMEN <input type="checkbox"/> NORTH BRANCH <input type="checkbox"/> OTHER	<input type="checkbox"/> NORTH <input type="checkbox"/> ROOMEN <input type="checkbox"/> NORTH BRANCH <input type="checkbox"/> OTHER
SCLER	<input type="checkbox"/> 3 PHASE BONE <input type="checkbox"/> TOTAL BONE BODY (WITH 3 PHASE IF NECESSARY) <input type="checkbox"/> WIS BONE <input type="checkbox"/> WIS BONE	<input type="checkbox"/> MIBG <input type="checkbox"/> RENAL (WITH LABS) <input type="checkbox"/> RENAL (WITHOUT LABS) <input type="checkbox"/> OTHER	<input type="checkbox"/> (WITH TOTAL BODY IF NECESSARY) <input type="checkbox"/> WITH ULTRASOUND IF NEEDED <input type="checkbox"/> BILATERAL <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT		
	<input type="checkbox"/> MAMMOGRAPHY (state no description or provider bring previous mammograms) <input type="checkbox"/> MAMMOGRAPHY (state no description or provider bring previous mammograms) <input type="checkbox"/> MAMMOGRAPHY (state no description or provider bring previous mammograms)				
MIBG	<input type="checkbox"/> LUNG PAIN THICKENING <input type="checkbox"/> NEEDLE ASP. BX <input type="checkbox"/> OTHER				
	<input type="checkbox"/> BONE DENSITOMETRY <input type="checkbox"/> LUNG PAIN THICKENING <input type="checkbox"/> NEEDLE ASP. BX <input type="checkbox"/> OTHER				
PROCEDURE		<input type="checkbox"/> CERVIX <input type="checkbox"/> BREAST EX <input type="checkbox"/> MIBG <input type="checkbox"/> OTHER			
<input type="checkbox"/> TELEPHONE REPORT (Please Patient) _____ <input type="checkbox"/> TELEPHONE REPORT (Please Patient) _____		PROVIDER Signature _____ Date _____ Signature (initials) are not valid			
MAKE ORDER FORM 2014 10-12 					