

## McLaren Print System Order

Order No: 9694  
 Order Date: 2015-03-10  
 User: Pamela Dietrich  
 Phone: 810 953 6400

Ship Location: Pam D  
 2313 East Hill Road  
 Grand Blanc, MI 48439

Forms  
 Quantity: 500  
 Paragon Dept No: 64050  
 Dept Name: 64050  
 Company Number: 60

Order Total Price: 0.00

Item Number: M-22016-B  
 Item Description: Imaging Center Order Form  
 Revision Date: 8/2013  
 Print: 2 sided black and white  
 Paper: 20# White Text  
 Size: 8.5 x 11  
 Fold:  
 Finish:  
 Drill: None  
 Misc Info:

|  |   |  |  |  |
|--|---|--|--|--|
|  |   | <b>FLINT</b><br>IMAGING CENTER<br>501 S. BALLENGER HWY., SUITE B- FLINT, MI 48906<br>PHONE: (810) 340-4000 FAX: (810) 340-4000 |  | IMPORTANT NOTICE<br>PLEASE BRING THIS FORM AND YOUR MEDICAL INSURANCE WITH YOU. AN ORDER WILL NOT BE PLACED IF NECESSARY THE FEE WILL BEAR TO BE RESPONSIBLE. SEE OTHER SIDE |
| NAME: _____ ADDRESS: _____ CITY: _____<br>CLINICAL DATA: _____ PROVIDER: _____   |   |  |  |  |
| REF: HISTORY: ADDRESS TO WHOM ORDER IS FOR: IF RES. PLEASE CALL OFFICE _____<br>PROVIDER(S) NAME: _____  |   |  |  |  |
| <b>R</b><br><b>A</b><br><b>T</b>   | X-RAY<br>FLUOROSCOPY <input type="checkbox"/> SWIM SWALLOW <input type="checkbox"/> UOI <input type="checkbox"/> IB <input type="checkbox"/> SE<br><input type="checkbox"/> WOOD SCOPES <input type="checkbox"/> IVP <input type="checkbox"/> VCUG <input type="checkbox"/> CYSTOGRAM<br><input type="checkbox"/> MISC: _____ - See Back of Order for Prep.   |  |  |  |
|  | U.S.<br><input type="checkbox"/> ABDOMEN <input type="checkbox"/> GALLBLADDER <input type="checkbox"/> TESTICLE (with or without if necessary) <input type="checkbox"/> RENAL DENERY<br><input type="checkbox"/> PROSTATE <input type="checkbox"/> OR (with or without if necessary) <input type="checkbox"/> BLADDER <input type="checkbox"/> BREAST LOCALIZATION <input type="checkbox"/> RENAL ARTERY<br><input type="checkbox"/> PELVIC (with or without if necessary) <input type="checkbox"/> TYPHOID <input type="checkbox"/> BREAST <input type="checkbox"/> OTHER _____<br>DOPPLER/DUPLEX <input type="checkbox"/> ARTERY <input type="checkbox"/> CROTCHES <input type="checkbox"/> ARTERIAL (with or without if necessary)<br><input type="checkbox"/> VEIN(S) <input type="checkbox"/> OTHER(S) _____   |  |  |  |
| <b>C</b><br><b>H</b><br><b>E</b><br><b>S</b><br><b>T</b>   | Site<br><input type="checkbox"/> ANKLE <input type="checkbox"/> FOREARM <input type="checkbox"/> FINGER <input type="checkbox"/> HEAD <input type="checkbox"/> CHEST <input type="checkbox"/> FEET <input type="checkbox"/> C-SPINE<br><input type="checkbox"/> CERVICAL NECK <input type="checkbox"/> HAND <input type="checkbox"/> SOFT TISSUE NECK <input type="checkbox"/> MIDDLE FINGER <input type="checkbox"/> SHOULDER <input type="checkbox"/> L-SPINE<br><input type="checkbox"/> EXTREMITY <input type="checkbox"/> UPPER <input type="checkbox"/> LOWER <input type="checkbox"/> WRIST <input type="checkbox"/> WRIST <input type="checkbox"/> FOREARM <input type="checkbox"/> FOREARM <input type="checkbox"/> FOREARM <input type="checkbox"/> FOREARM<br><input type="checkbox"/> WREST/WRIST <input type="checkbox"/> OTHER _____ - See Back of Order for Prep.<br><input type="checkbox"/> CHEST <input type="checkbox"/> OTHER _____ |  |  |  |
|  | SPINE/CX<br><input type="checkbox"/> 3 PHASE BONE C. _____ WITH TOTAL BODY IF NECESSARY<br><input type="checkbox"/> TOTAL BONE BODY (WITH 3 PHASE IF NECESSARY)<br><input type="checkbox"/> VIO SCANS <input type="checkbox"/> MUGA <input type="checkbox"/> LEUKOCYTE SCAN <input type="checkbox"/> RENAL (WITH/OUT LASSO) <input type="checkbox"/> OTHER _____<br><input type="checkbox"/> HEA SCANS <input type="checkbox"/> RENAL (WITH/OUT LASSO) <input type="checkbox"/> RENAL (WITH/OUT LASSO) <input type="checkbox"/> OTHER _____   |  |  |  |
| <b>B</b><br><b>R</b><br><b>E</b><br><b>A</b><br><b>S</b><br><b>T</b>   | <input type="checkbox"/> SPERMICIDALITY (order to doctor or provider using previous measurements)<br><input type="checkbox"/> SCREENING <input type="checkbox"/> DIAGNOSTIC (WITH ULTRASOUND IF NECESSARY)<br>CHECK THESE FOR DIAGNOSTIC STUDY<br><input type="checkbox"/> BREAST CA-15 <input type="checkbox"/> BREAST/BREAST BI-15 <input type="checkbox"/> PERSONAL USE (CERVIX) <input type="checkbox"/> CERVIX <input type="checkbox"/> ENDOMETRIAL<br><input type="checkbox"/> UMBILICAL TRACHEOGRAM <input type="checkbox"/> MYELO SCI <input type="checkbox"/> ANORMAL BARM <input type="checkbox"/> OTHER _____<br>BONE DENSITOMETRY <input type="checkbox"/> C-15 SPINE/HP  |  |  |  |
|  | RADIOGRAPHY<br><input type="checkbox"/> 1/2 IN AP <input type="checkbox"/> CERVICAL X-RAY <input type="checkbox"/> HYSTEROGRAM/PISTOGRAM <input type="checkbox"/> ANTHROGRAM<br><input type="checkbox"/> BREAST BK <input type="checkbox"/> STEREO <input type="checkbox"/> UR CORO <input type="checkbox"/> PANORAMIC/PERIAP <input type="checkbox"/> SITE<br><input type="checkbox"/> MYELOGRAM <input type="checkbox"/> NEEDLE AD-15 <input type="checkbox"/> OTHER _____<br><input type="checkbox"/> MISC: _____  |  |  |  |
| <input type="checkbox"/> TELEPHONE REPORT (Please Refer to) _____<br><input type="checkbox"/> TELEPHONE REPORT (Please Refer to) _____<br>Physician Signature/Date: _____<br>Consent will be added as necessary to optimize the diagnostic capability of the exam. Additional studies will be performed as medically necessary to optimize the diagnostic capability of the study that is being performed (e.g., views from an abnormal bone scan). Signifying form indicates your agreement of the above. |   |  |  |  |
| IMAGE ORDER FORM<br>0000   |   |  |  |  |