

McLaren Print System Order

Order No: 45541
 Order Date: 2019-05-22
 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 _____
FLINT				Appointment Time _____
(CHECK ONE) VISIT TYPE: _____ McLaren Imaging Center • Ph: 810.342.4800 Fax: 810.342.4808 McLaren 501 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 _____		
MR	<input type="checkbox"/> U/S <input type="checkbox"/> MRI <input type="checkbox"/> PET	PET	<input type="checkbox"/> INITIAL STAGING <input type="checkbox"/> BRILL TO WHO FRAGS <input type="checkbox"/> METASTATIC VIABILITY <input type="checkbox"/> NEW BONE SCANS	<input type="checkbox"/> SUBSEQUENT <input type="checkbox"/> BRILL TO WHO (MELANOMA) <input type="checkbox"/> BRILL TO WHO (NON-MELANOMA) <input type="checkbox"/> SULFUR-35 OR SULFUR-35
X-RAY	<input type="checkbox"/> FLUOROSCOPY <input type="checkbox"/> BIPLANAR THORAX <input type="checkbox"/> NEED ESCAN GENERAL X-RAY NO APPOINTMENT NEEDED	<input type="checkbox"/> LD <input type="checkbox"/> RP <input type="checkbox"/> VQUS <input type="checkbox"/> CT/TOGRAM	<input type="checkbox"/> SS <input type="checkbox"/> SE	- See Back of Order for Page
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"/> NORTH <input type="checkbox"/> VENOUS <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"/> TESTICLE (WITH COLOR FLOW IF NECESSARY) <input type="checkbox"/> BLADDER <input type="checkbox"/> THYROID <input type="checkbox"/> CAROTID <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"/> COLORFLOW IF NECESSARY <input type="checkbox"/> OTHER	
CT	<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-RESOLUTION <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 - See Back of Order for Page	<input type="checkbox"/> CTR <input type="checkbox"/> NORTH <input type="checkbox"/> SOUTH <input type="checkbox"/> EXTREMITY <input type="checkbox"/> NORTH BRANCH <input type="checkbox"/> CHEST <input type="checkbox"/> OTHER	
SCANS	<input type="checkbox"/> 3 PHASE BONE <input type="checkbox"/> TOTAL BONE BODY (WITH 3 PHASE IF NECESSARY) <input type="checkbox"/> VIB SCAN <input type="checkbox"/> HIDA SCAN	<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"/> (WITH ULTRASOUND IF NEEDED) <input type="checkbox"/> BILATERAL <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT	
BIOPSY	<input type="checkbox"/> MAMMOGRAPHY (with no description or provider bring previous mammograms) <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"/> SINGLE D/C <input type="checkbox"/> ABNORMAL MAMM <input type="checkbox"/> OTHER	<input type="checkbox"/> (WITH ULTRASOUND IF NEEDED) <input type="checkbox"/> BILATERAL <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT	<input type="checkbox"/> (WITH ULTRASOUND IF NEEDED) <input type="checkbox"/> BILATERAL <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT	
PROCEDURE	<input type="checkbox"/> EYE/OPHTHALM <input type="checkbox"/> BREAST EX <input type="checkbox"/> MISC/SCAN <input type="checkbox"/> OTHER	<input type="checkbox"/> SALICITURAM <input type="checkbox"/> US-GONE <input type="checkbox"/> NEEDLE ASP. EX	<input type="checkbox"/> LUMBAL PUNCTURE <input type="checkbox"/> HYSTEROGRAM PROGRAM <input type="checkbox"/> PAIN MANAGEMENT	<input type="checkbox"/> APTHOGRAM
<input type="checkbox"/> TELEPHONE REPORT (Please Print) _____ <input type="checkbox"/> TELEPHONE REPORT (Please Print) _____		PROVIDER Signature _____ Date _____ Time _____ Signature Errors are NOT valid		
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 quality of the study that is being performed (e.g., a scan for an abnormal bone scan). Signing this form indicates your agreement of the above.				

Spec Info:

