

## McLaren Print System Order

Order No: 49751  
 Order Date: 2019-10-24  
 User: Jodi Peterman  
 Phone: 3422133

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

### Forms

Quantity: 50  
 Paragon Dept No: 32113  
 Dept Name: McLaren Flint MRI Ballenger  
 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<br>FLINT  |   | OUTPATIENT RADIOLOGY<br>ORDER FORM  |   | Appointment Date _____  | Appointment Time _____  |
|---|---|---|---|---|---|
| (OPTIONAL) WEST 75000<br>McLaren Imaging Center • Ph: 810.342.4800 Fax: 810.342.4808<br>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<br><input type="checkbox"/> GREY<br><input type="checkbox"/> GREY   | INITIAL STAGING<br><input type="checkbox"/> BRILL TO NEO FLUIDS<br><input type="checkbox"/> ANGIOGRAPHIC VIABILITY<br><input type="checkbox"/> NEW BONE SCANS | <input type="checkbox"/> SUBSEQUENT<br><input type="checkbox"/> BRILL TO NEO FLUIDS<br><input type="checkbox"/> BRILL TO NEO FLUIDS<br><input type="checkbox"/> BRILL TO NEO FLUIDS |   |   |
|   | GENERAL MRI NO APPOINTMENT NEEDED   |   |   |   |   |
| X-RAY   | <input type="checkbox"/> FLUOROSCOPY<br><input type="checkbox"/> BILAT SWALLOW<br><input type="checkbox"/> NEED ESCAN   | <input type="checkbox"/> LD<br><input type="checkbox"/> RP  | <input type="checkbox"/> SS<br><input type="checkbox"/> VCUS  | <input type="checkbox"/> SE<br><input type="checkbox"/> CHSTGRAM  | - See Back of<br>Order for Prep   |
|   | GENERAL X-RAY NO APPOINTMENT NEEDED   |   |   |   |   |
| US  | <input type="checkbox"/> PELVIC (WITH TRANS VAG IF NECESSARY)<br><input type="checkbox"/> ABDOMEN<br><input type="checkbox"/> PROSTATE<br><input type="checkbox"/> COLOR DOPPLER          | <input type="checkbox"/> BLADDER<br><input type="checkbox"/> THYROID<br><input type="checkbox"/> CAROTID  | <input type="checkbox"/> BREAST (COLOR FLOW IF NECESSARY)<br><input type="checkbox"/> BREAST FOUNDATION<br><input type="checkbox"/> BREAST  | <input type="checkbox"/> RENAL/KIDNEY<br><input type="checkbox"/> RENAL ARTERY<br><input type="checkbox"/> OTHER  | <input type="checkbox"/> OTHER  |
|   | EB <input type="checkbox"/> ESD <input type="checkbox"/> LESS THAN 10 BKS <input type="checkbox"/> MORE THAN 10 BKS <input type="checkbox"/> LIMITED <input type="checkbox"/> BIOPHYSICAL |   |   |   |   |
| CT  | <input type="checkbox"/> HEAD<br><input type="checkbox"/> SOFT TISSUE NECK<br><input type="checkbox"/> SPINE<br><input type="checkbox"/> OTHER  | <input type="checkbox"/> CHEST<br><input type="checkbox"/> HIGH-RES CHEST<br><input type="checkbox"/> ABDOMEN<br><input type="checkbox"/> UROGRAM             | <input type="checkbox"/> PELVIS<br><input type="checkbox"/> SPINE<br><input type="checkbox"/> RENAL STONE<br><input type="checkbox"/> UROGRAM                                       | <input type="checkbox"/> C-SPINE<br><input type="checkbox"/> T-SPINE<br><input type="checkbox"/> L-SPINE<br><input type="checkbox"/> EXTREMITY<br><input type="checkbox"/> NORTH BRANCH<br><input type="checkbox"/> CHEST | CTN<br><input type="checkbox"/> NORTH <input type="checkbox"/> ROOMEN <input type="checkbox"/> ROOMEN/PELVIS<br><input type="checkbox"/> CONFIRMED <input type="checkbox"/> HEAD<br><input type="checkbox"/> UPPER <input type="checkbox"/> LOWER <input type="checkbox"/> LR |
|   | - See Back of Order for Prep  |   |   |   |   |
| SCLER   | <input type="checkbox"/> 3 PHASE BONE<br><input type="checkbox"/> TOTAL BONE BODY (WITH 3 PHASE IF NECESSARY)<br><input type="checkbox"/> W/O SCAN<br><input type="checkbox"/> W/O SCAN   | <input type="checkbox"/> MESA<br><input type="checkbox"/> RENAL (WITH LABS)<br><input type="checkbox"/> RENAL (WITHOUT LABS)                                  | <input type="checkbox"/> (WITH TOTAL BODY IF NECESSARY)<br><input type="checkbox"/> WITH ULTRASOUND IF NEEDED<br><input type="checkbox"/> BILATERAL                                 | <input type="checkbox"/> LEFT<br><input type="checkbox"/> RIGHT   | <input type="checkbox"/> BONE DENSITOMETRY<br><input type="checkbox"/> U.S. SPINE/HP  |
|   | - See Back of Order for Prep  |   |   |   |   |
| MISC  | <input type="checkbox"/> MAMMOGRAPHY (state no description or provider, bring previous mammograms)<br><input type="checkbox"/> A/D SCREENING<br><input type="checkbox"/> B/D SCREENING    |   |   |   |   |
|   | - See Back of Order for Prep  |   |   |   |   |
| PROCEDURE: <input type="checkbox"/> EYE/OPHTHALM <input type="checkbox"/> SALICITINURAM <input type="checkbox"/> LUMBAL PUNCTURE<br><input type="checkbox"/> BREAST EX <input type="checkbox"/> STEREO <input type="checkbox"/> US-CONE <input type="checkbox"/> HYSTEROSALPINGOGRAM <input type="checkbox"/> ARTHROGRAM<br><input type="checkbox"/> MISC/GRAM <input type="checkbox"/> NEEDLE ASP. EX <input type="checkbox"/> PAIN MANAGEMENT |   |   |   |   |   |
| <input type="checkbox"/> TELEPHONE REPORT (Please Patient) _____<br><input type="checkbox"/> TELEPHONE REPORT (Please Patient) _____  |   | PROVIDER Signature _____<br>Date _____ Time _____<br>Signature (initials) are not valid   |   |   |   |
| MAKE ORDER FORM<br>2014 10-12<br>6602   |   |   |   |   |   |

Spec Info:

Contract will be added as 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.