

McLaren Print System Order

Order No: 51497
 Order Date: 2020-01-07
 User: Jennifer Dixon
 Phone: 810.342.2138

Ship Location: MIC/Jeni 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 _____	
(CHECK) VISIT TYPE _____ 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 _____		PRI 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"/> MEDIA <input type="checkbox"/> OTHER _____	<input type="checkbox"/> INITIAL STAGING <input type="checkbox"/> BRILL TO WHO FRAGS <input type="checkbox"/> ANGIOGRAPHIC VIABILITY <input type="checkbox"/> NEW BONE SCANS	<input type="checkbox"/> SUBSEQUENT <input type="checkbox"/> BRICKLE BODY (MELANOMA) <input type="checkbox"/> BRAIN ANGIOGRAPHY/ANOMALY <input type="checkbox"/> GALLBLADDER CALCULI			
	<input type="checkbox"/> FLUOROSCOPY <input type="checkbox"/> BILATERAL SWALLOW <input type="checkbox"/> LUD <input type="checkbox"/> SB <input type="checkbox"/> SE <input type="checkbox"/> CHYSTOGRAM <input type="checkbox"/> OTHER _____ - See Back of Order for Page					
US	<input type="checkbox"/> PELVIC (WITH TRANS VAG IF NECESSARY) <input type="checkbox"/> ABDOMEN <input type="checkbox"/> OB/GYN <input type="checkbox"/> PROSTATE <input type="checkbox"/> COLOR DOPPLER <input type="checkbox"/> NORTH <input type="checkbox"/> VENOUS	<input type="checkbox"/> TESTICLES (WITH COLOR FLOW IF NECESSARY) <input type="checkbox"/> BLADDER <input type="checkbox"/> BREAST FOUNDATION <input type="checkbox"/> RENAL ARTERY <input type="checkbox"/> THYROID <input type="checkbox"/> BREAST <input type="checkbox"/> CAROTIDS <input type="checkbox"/> ARTERIAL (COLORFLOW IF NECESSARY) <input type="checkbox"/> OTHER _____	<input type="checkbox"/> RENAL/KIDNEY <input type="checkbox"/> RENAL ARTERY <input type="checkbox"/> OTHER _____			
	<input type="checkbox"/> EB <input type="checkbox"/> LESS THAN 10 WKS <input type="checkbox"/> MORE THAN 10 WKS <input type="checkbox"/> LIMITED <input type="checkbox"/> BIOPHYSICAL					
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 _____ - See Back of Order for Page	<input type="checkbox"/> PELVIS <input type="checkbox"/> SPINE <input type="checkbox"/> RENAL STONE <input type="checkbox"/> OTHER _____	<input type="checkbox"/> CTR <input type="checkbox"/> NORTH <input type="checkbox"/> ROOMEN <input type="checkbox"/> ROOMEN/PELVIS <input type="checkbox"/> CONFIRMED <input type="checkbox"/> HEAD <input type="checkbox"/> EXTREMITY <input type="checkbox"/> UPPER <input type="checkbox"/> LOWER <input type="checkbox"/> LR <input type="checkbox"/> NORTH BRANCH <input type="checkbox"/> CHEST <input type="checkbox"/> OTHER _____		
	<input type="checkbox"/> 3 PHASE BONE (WITH TOTAL BODY IF NECESSARY) <input type="checkbox"/> TOTAL BONE BODY (WITH 3 PHASE IF NECESSARY) <input type="checkbox"/> TIBI SCAN <input type="checkbox"/> MEDIA <input type="checkbox"/> LEUKOCYTE SCANS - BONE MARROW <input type="checkbox"/> HIDA SCAN <input type="checkbox"/> RENAL (WITH/LABE) <input type="checkbox"/> RENAL (WITHOUT LABE) <input type="checkbox"/> OTHER _____					
MIBT	<input type="checkbox"/> MAMMOGRAPHY (state no deviation or problem being previous mammogram) <input type="checkbox"/> AD SCREENING <input type="checkbox"/> BI SCREENING <input type="checkbox"/> WITH ULTRASOUND IF NEEDED <input type="checkbox"/> BILATERAL <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/> BIOPHYSICAL FOR DIAGNOSTIC STUDY					
	<input type="checkbox"/> LUMP PAIR THICKENING <input type="checkbox"/> NIPPLE D/C <input type="checkbox"/> ABNORMAL MAMM <input type="checkbox"/> OTHER _____ <input type="checkbox"/> BONE DENSITOMETRY <input type="checkbox"/> U.S. SPINE/HP					
<input type="checkbox"/> TELEPHONE REPORT (Please Patient) _____ <input type="checkbox"/> TELEPHONE REPORT (Please Patient) _____		PROVIDER Signature _____ Date _____ Time _____ Signature Errors are NOT valid				
MAKE ORDER FORM 5001 1/01/12 5001						

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 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.