

## McLaren Print System Order

Order No: 53463  
 Order Date: 2020-03-24  
 User: Jodi Peterman  
 Phone: 3422133

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

### Forms

Quantity: 36  
 Paragon Dept No: 32113  
 Dept Name: McLaren Flint MRI Ballenger  
 Company Number: 60

Order Total Price: 471.60

Item Number: M-22016-B  
 Item Description: Imaging Center Order Form  
 Revision Date: 2/2020  
 Print:  
 Paper:  
 Size:  
 Fold:  
 Finish:  
 Drill:  
 Misc Info: ds; full color; 50 Sheets per pad. Please order how many pads you would like. BW

		<b>OUTPATIENT RADIOLOGY ORDER FORM</b>		Appointment Date _____
FLINT				Appointment Time _____
(OPTIONAL) 1000 N. WALTON BLVD McLaren Imaging Center • Ph: 810.342.4800 Fax: 810.342.4808 McLaren MRI 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 _____		
<b>MRI</b>	<input type="checkbox"/> GREY <input type="checkbox"/> GREY <input type="checkbox"/> GREY	<input type="checkbox"/> MRI HEART W/WO <input type="checkbox"/> MRI HEART W/O <input type="checkbox"/> MRI HEART VELOCITY FLOW MAP	<input type="checkbox"/> CTX HEART W/WO <input type="checkbox"/> CTX HEART W/O <input type="checkbox"/> CTX HEART (CALCIUM SCORING)	
<b>X-RAY</b>	<input type="checkbox"/> FLUOROSCOPY <input type="checkbox"/> GENERAL X-RAY NO APPOINTMENT NEEDED	<input type="checkbox"/> BILAT SWALLOW <input type="checkbox"/> LUD <input type="checkbox"/> NP	<input type="checkbox"/> SS <input type="checkbox"/> VQUS <input type="checkbox"/> SE <input type="checkbox"/> CHSTOGRAM	- See Back of Order for Page
<b>US</b>	<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"/> TESTICLE (WITH COLOR FLOW IF NECESSARY) <input type="checkbox"/> BLADDER <input type="checkbox"/> THYROID <input type="checkbox"/> CAROTID	<input type="checkbox"/> BREAST (ULTRASONOGRAPHY) <input type="checkbox"/> BREAST (COLOR FLOW) <input type="checkbox"/> BREAST (DOPPLER) <input type="checkbox"/> OTHER	<input type="checkbox"/> RENAL/KIDNEY <input type="checkbox"/> RENAL ARTERY
<b>EB</b>	<input type="checkbox"/> LESS THAN 10 WKS <input type="checkbox"/> MORE THAN 10 WKS	<input type="checkbox"/> LIMITED <input type="checkbox"/> UNLIMITED	<input type="checkbox"/> SONOGRAPHIC	
<b>CT</b>	<input type="checkbox"/> HEAD <input type="checkbox"/> SOFT TISSUE NECK <input type="checkbox"/> STEREO <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"/> T-Spine <input type="checkbox"/> L-Spine <input type="checkbox"/> OTHER	<input type="checkbox"/> CTX <input type="checkbox"/> NORTH <input type="checkbox"/> ROOMEN <input type="checkbox"/> ROOMEN/PELVIS <input type="checkbox"/> CONFIRMED <input type="checkbox"/> EXTREMITY <input type="checkbox"/> NORTH BRANCH <input type="checkbox"/> CHEST
<b>NUCLEAR</b>	<input type="checkbox"/> 3 PHASE BONE <input type="checkbox"/> TOTAL BONE BODY <input type="checkbox"/> TIBI SCAN <input type="checkbox"/> HIDA SCAN	<input type="checkbox"/> (WITH TOTAL BODY IF NECESSARY) <input type="checkbox"/> (WITH ULTRASONOGRAPHY IF NEEDED) <input type="checkbox"/> MIBG <input type="checkbox"/> RENAL (WITH LABS) <input type="checkbox"/> RENAL (WITHOUT LABS)	<input type="checkbox"/> (WITH ULTRASONOGRAPHY IF NEEDED) <input type="checkbox"/> (WITH ULTRASONOGRAPHY IF NEEDED) <input type="checkbox"/> (WITH ULTRASONOGRAPHY IF NEEDED) <input type="checkbox"/> (WITH ULTRASONOGRAPHY IF NEEDED)	
<b>BIOPSY</b>	<input type="checkbox"/> BIOPSY (WITH OR WITHOUT PREVIOUS IMAGING) <input type="checkbox"/> BIOPSY (WITH OR WITHOUT PREVIOUS IMAGING)	<input type="checkbox"/> BIOPSY (WITH OR WITHOUT PREVIOUS IMAGING) <input type="checkbox"/> BIOPSY (WITH OR WITHOUT PREVIOUS IMAGING)	<input type="checkbox"/> BIOPSY (WITH OR WITHOUT PREVIOUS IMAGING) <input type="checkbox"/> BIOPSY (WITH OR WITHOUT PREVIOUS IMAGING)	
<b>PROCEDURE</b>	<input type="checkbox"/> EYE/OPHTHALMOLOGY <input type="checkbox"/> BREAST EX <input type="checkbox"/> MISC/GENERAL <input type="checkbox"/> OTHER	<input type="checkbox"/> SALICITINURAM <input type="checkbox"/> US-GONE <input type="checkbox"/> NEEDLE ASP. EX	<input type="checkbox"/> LUMBAL PUNCTURE <input type="checkbox"/> HYSTEROSALPINGOGRAM <input type="checkbox"/> PAIN MANAGEMENT	<input type="checkbox"/> ANTHROGRAM
<input type="checkbox"/> TELEPHONE REPORT (Please Print) _____ <input type="checkbox"/> TELEPHONE REPORT (Please Print) _____		PROVIDER Signature _____ Date _____ Time _____		
Contract within order is 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 CT scan for an abdominal tumor scan). Signing this form indicates your agreement of the above.				

Spec Info: