McLaren

DIAGNOSTIC IMAGING

50 North Perry Street
Pontiac, MI 48342
Scheduling: 248-338-5608
Phone: 248-338-5604
Fax: 248-338-5605

385 N. Lapeer Road
Oxford, MI 48371
Phone: 248-620-5012
Fax: 248-620-5013

5701 Bow Pointe Drive, Suite 110
Clarkston, MI 48346
Phone: 248-620-5012
Fax: 248-620-5013

PLEASE REMEMBER TO BRING THIS FORM TO YOUR APPOINTMENT

Your appointment is scheduled on: Date: _____ Time: _____

Patient Name:		DOB: / / /
Print Ordering Physician's Name:		Signature:
Physician's Phone #	Fax Number	Date Ordered:
Diagnosis:		

GENERAL RADIOLOGY

Exam(s) Requested: _____Left _____Right Bilateral

Bone Density (DEXA SCAN)_____

NUCLEAR MEDICINE

- ☐ Bone Scan Whole Body
- ☐ Bone Scan Limited
- ☐ Bone Scan 3 Phase
- ☐ Gastric Emptying Study
- ☐ Hida Scan w/CCK
- ☐ Hida Scan w/o CCK
- ☐ Muga Scan
- ☐ Myocardial Stress - Exercise
- ☐ Myocardial Stress - Pharmalogical
- ☐ Other: _____

CAT SCAN (If labs required, they have to be valid within 30 days of patient being injected.)

Contrast option MUST be selected: _____***Without*** _____***With*** _____***With & Without***

CURRENT (within 30 days) LAB RESULTS: BUN:_____ Creatitine:_____ Date performed: _____

- _____ Abdomen
- _____ Abdomen / Pelvis
- _____ Abdomen / Pelvis Stone Protocol
- _____ Brain / Head
- _____ Chest
- _____ Extremity Area: _____
  ____Lower_____Upper_____Left_____Right
- _____ *Low dose Lung cancer screening (include eligibility order) Medicare - patient is eligible for one screening exam/year if eligibility is met
- _____ Neck Soft Tissue / Salivary Gland
- _____ Pelvis _____ Orbits
- _____ Sinus _____ Facial Bones
- _____ Spine - Cervical Levels_____
- _____ Spine - Thoracic Levels _____
- _____ Spine - Lumbar Levels _____
- _____ High Resolution Chest
- _____ IAC/Mastoids
- _____ Other: _____

CTA STUDIES

- _____ Abdominal Aorta
- _____ Renal Arteries and Thoracic Aorta
- _____ Abdominal Aorta with Extremity Runoff
- _____ Brain - Circle of Willis
- _____ Carotids
- _____ Pelvis
- _____ Pulmonary Emboli
- _____ Extremity Area: _____
  _____Lower _____Upper

ULTRASOUND

- _____ Abdomen - Complete
- _____ Abdomen - Limited
- _____ Breast - Complete
- _____ Breast - Limited
- _____ Extremity Area: _____
  ____Lower_____Upper_____Left_____Right
- _____ Kidneys / Bladder
- _____ Pelvis w/Transvaginal (if necessary)
- _____ Pregnancy 1st Trimester w/Transvaginal (if necessary)
- _____ Transvaginal Only
- _____ Testicles w/Doppler
- _____ Carotid Doppler
- _____ Venous Doppler
  _____Upper Left _____Upper Right
  _____Lower Left _____Lower Right
- _____ Venous Doppler - Bilateral

Other:

EXAM PREPARATIONS **Instructions are also provided when scheduling the appointment(s).**

CAT SCAN

Nothing to eat or drink 2 hours prior to exam

Check with your medical insurance provider to confirm if an authorization is needed for your CT scan.

Contrasted studies may need lab work prior to CT scan. Please contact the scheduling department with any questions.

GENERAL RADIOLOGY

Instructions (if applicable) will be given when appointment is made.

MAMMOGRAM

No deodorant or baby powder day of exam

No caffeine 72 hours prior to exam

Bring prior mammogram studies with you for your appointment.

NUCLEAR MEDICINE

Instructions (if applicable) will be given when appointment is made.

ULTRASOUND

Abdomen Complete or Limited	Nothing to eat or drink after midnight
Kidneys / Bladder	Drink 20 ounces of water 1 hour prior to exam. DO NOT URINATE; bladder must be full.
Pelvis Non-OB	Drink 20 ounces of water 1 hour prior to exam. DO NOT URINATE; bladder must be full.
Pelvis 1st Trimester	Drink 20 ounces of water 1 hour prior to exam. DO NOT URINATE; bladder must be full.