

McLaren Print System Order

Order No: 73370
 Order Date: 2022-10-31
 User: Jennifer Dixon
 Phone: 810.342.2138

Ship Location: Jeni Dixon/Imaging Center
 501 S Ballenger Hwy , Suite B
 Flint, MI 48532

Forms
 Quantity: 50
 Paragon Dept No: 32011
 Dept Name: Imaging Center
 Company Number: 60

Order Total Price: 655.00

Item Number: M-22016-B
 Item Description: Imaging Center Order Form
 Revision Date: 7/2021
 Print:
 Paper:
 Size:
 Fold:
 Finish:
 Drill:
 Poster:
 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 _____
Patient Name _____ DOB _____ Height _____ Weight _____ RESIDENT PHONE _____ INSURANCE _____ PRI AUTHORIZATION NUMBER _____ DIAGNOSIS/REASON FOR EXAM (PLEASE INCLUDE LATERALITY, SPECIFIC SITE) _____ ORDERING PROVIDER (PRINT NAME) _____ OFFICE CONTACT _____				
MR	<input type="checkbox"/> MR <input type="checkbox"/> MRA <input type="checkbox"/> MRV	<input type="checkbox"/> MR HEART W/O <input type="checkbox"/> MR HEART W/0 <input type="checkbox"/> MR HEART VELOCITY FLOW MAP	<input type="checkbox"/> CTX HEART W/O <input type="checkbox"/> CT HEART CALCIUM SCORING	
X-RAY	<input type="checkbox"/> X-RAY <input type="checkbox"/> FLUOROSCOPY <input type="checkbox"/> BARIUM SWALLOW <input type="checkbox"/> VIDEO ESOPH GENERAL X-RAY NO APPOINTMENT NEEDED	<input type="checkbox"/> L/D <input type="checkbox"/> R/F <input type="checkbox"/> SS <input type="checkbox"/> VCUG <input type="checkbox"/> SE <input type="checkbox"/> CISTOGRAM		- 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"/> EXTREMITY (MSK) <input type="checkbox"/> OB	<input type="checkbox"/> TESTICLE (WITH COLOR FLOW IF NECESSARY) <input type="checkbox"/> BLADDER <input type="checkbox"/> TONGUE <input type="checkbox"/> DYNACOLOR <input type="checkbox"/> OTHER	<input type="checkbox"/> RENAL ARTERY <input type="checkbox"/> RENAL VEIN <input type="checkbox"/> BREAST (DOPPLER) <input type="checkbox"/> ARTERIAL (COLORFLOW IF NECESSARY) <input type="checkbox"/> OTHER	
CT	<input type="checkbox"/> HEAD <input type="checkbox"/> NECK <input type="checkbox"/> CHEST <input type="checkbox"/> HIGH-RES CHEST <input type="checkbox"/> ABDOMEN <input type="checkbox"/> OTHER	<input type="checkbox"/> PELVIS <input type="checkbox"/> NEURAL <input type="checkbox"/> RENAL STONE <input type="checkbox"/> UROGRAM	<input type="checkbox"/> CTN <input type="checkbox"/> ABDOMEN <input type="checkbox"/> EXTREMITY <input type="checkbox"/> SCAPULACRY <input type="checkbox"/> OTHER	
MAGNETIC	<input type="checkbox"/> PINKIE BONE <input type="checkbox"/> TOTAL BONE BODY <input type="checkbox"/> VIB SCAN <input type="checkbox"/> MOA SCAN	<input type="checkbox"/> (WITH TOTAL BODY IF NECESSARY) <input type="checkbox"/> (IF NECESSARY) <input type="checkbox"/> MUGA <input type="checkbox"/> RENAL (WITH LADN) <input type="checkbox"/> RENAL (WITHOUT LADN) <input type="checkbox"/> OTHER	<input type="checkbox"/> LEUKOCYTE SCAN (BONE MARRROW) <input type="checkbox"/> OTHER	
BREAST	<input type="checkbox"/> MAMMOGRAPHY (WITH TRANSVAG IF NECESSARY) <input type="checkbox"/> BILATERAL <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/> LUMP PAIR THICKENING <input type="checkbox"/> MIPPLE D/C <input type="checkbox"/> BONE DENSITOMETRY	<input type="checkbox"/> OTHER	<input type="checkbox"/> BI-PLANAR <input type="checkbox"/> SCREENING <input type="checkbox"/> OTHER	
PROCEDURE	<input type="checkbox"/> CYST ASPIRATION <input type="checkbox"/> BRUSH BI <input type="checkbox"/> MFLC/GRAM <input type="checkbox"/> OTHER	<input type="checkbox"/> SALICITIN <input type="checkbox"/> US-LONE <input type="checkbox"/> NEEDLE ASP BX	<input type="checkbox"/> LUNGASPIRATION <input type="checkbox"/> MFLC/GRAM <input type="checkbox"/> PAIN MANAGEMENT <input type="checkbox"/> ARTHROGRAM	
<input type="checkbox"/> TELEPHONE REPORT (Print Patient) <input type="checkbox"/> TELEPHONE REPORT (Release Patient)		PROVIDER Signature _____ Date _____ Time _____ Signature STAMPS ARE NOT VALID		
Contract within added as necessary to optimize the diagnostic capability of the exam. Additional studies will be performed as medically necessary to optimize the diagnostic capability of the study that is being performed (e.g., a scope for an abnormal bone scan). Signing this form indicates your agreement of the above.				

Spec Info: asap please