

## McLaren Print System Order

Order No: 76175  
 Order Date: 2023-03-30  
 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: 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 _____	
16000 WILSON BLVD McLaren Imaging Center • Ph: 810.342.4800 Fax: 810.342.4830 McLaren MRI Ballenger Hwy • Ph: 810.225.3071 Fax: 810.225.3076 McLaren Flint MRI Imaging Services • Ph: 810.426.2000 Fax: 810.426.2040						
Patient Name _____ DOB _____ Height _____ Weight _____		CURRENT 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"/> MRI <input type="checkbox"/> MRIA <input type="checkbox"/> MRV	<input type="checkbox"/> MRI HEART W/O <input type="checkbox"/> MRI HEART W/0 <input type="checkbox"/> MRI HEART VELOCITY FLOW MAP	<input type="checkbox"/> CTX HEART W/O <input type="checkbox"/> CTX HEART CALCIUM SCORING			
<b>X-RAY</b>	<input type="checkbox"/> X-RAY <input type="checkbox"/> FLUOROSCOPY GENERAL X-RAY NO APPOINTMENT NEEDED	<input type="checkbox"/> SKULL BILLOWAL <input type="checkbox"/> VIDEO ESOPIH <input type="checkbox"/> LUD <input type="checkbox"/> RIF	<input type="checkbox"/> SS <input type="checkbox"/> VCUG <input type="checkbox"/> SE <input type="checkbox"/> CISTOGRAM	- 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"/> EXTREMITY / MSK SB <input type="checkbox"/> EGD <input type="checkbox"/> ESD	<input type="checkbox"/> TESTICLE (WITH COLOR FLOW IF NECESSARY) <input type="checkbox"/> BLADDER <input type="checkbox"/> TONGUE <input type="checkbox"/> CERVIX <input type="checkbox"/> OTHER	<input type="checkbox"/> RENAL KIDNEY <input type="checkbox"/> BREAST (DOPPLER) <input type="checkbox"/> BREAST (COLOR FLOW) <input type="checkbox"/> ARTERIAL (COLOR FLOW IF NECESSARY)			
<b>CT</b>	<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"/> C-SPINE <input type="checkbox"/> T-SPINE <input type="checkbox"/> L-SPINE	<input type="checkbox"/> CTX <input type="checkbox"/> ABDOMEN <input type="checkbox"/> EXTREMITY <input type="checkbox"/> OTHER	- See Back of Order for Page	
<b>BONE</b>	<input type="checkbox"/> PRONE BONE <input type="checkbox"/> VIO SCANS <input type="checkbox"/> HIDA SCANS	<input type="checkbox"/> WITH TOTAL BODY IF NECESSARY <input type="checkbox"/> WITH BONE IF NECESSARY <input type="checkbox"/> MUGA <input type="checkbox"/> RENAL (WITH LADG) <input type="checkbox"/> RENAL (WITHOUT LADG)	<input type="checkbox"/> LEUKOCYTE SCANS (BONE MARRON) <input type="checkbox"/> OTHER			
<b>BREAST</b>	<input type="checkbox"/> MAMMOGRAPHY (with no compression or provide breast compression mammograms) <input type="checkbox"/> MAMMOGRAPHY (with compression) <input type="checkbox"/> BILATERAL <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT CHECK THESE FOR DIAGNOSTIC STUDY <input type="checkbox"/> LUMP PAIR THICKENING <input type="checkbox"/> MIPPLE D/C <input type="checkbox"/> ABNORMAL MAMM <input type="checkbox"/> OTHER BONE DENSITOMETRY <input type="checkbox"/> L-S-SPINE-HP					
<input type="checkbox"/> TELEPHONE REPORT (Print Patient) <input type="checkbox"/> TELEPHONE REPORT (Release Patient)		PROVIDER Signature _____ Date _____ Time _____ Signature stamps are not valid				
Contract will be 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 scan for an abnormal bone scan). Signing this form indicates your agreement of the above.						

Spec Info: