

## McLaren Print System Order

Order No: 82574  
 Order Date: 2024-01-24  
 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: McLaren 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<br>FLINT  |  | OUTPATIENT RADIOLOGY<br>ORDER FORM  |  | Appointment Date _____  | Appointment Time _____       |
|---|--|---|--|---|------------------------------|
| ORDERING FACILITY NAME: <b>McLaren Imaging Center</b> • Ph: 810.342.4800 Fax: 810.342.4830<br><b>McLaren MRI Ballenger Hwy</b> • Ph: 810.225.3071 Fax: 810.225.3078<br><b>McLaren Flinton Imaging Services</b> • 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<br><input type="checkbox"/> MRIA<br><input type="checkbox"/> MRV  | <input type="checkbox"/> MRI HEART W/O<br><input type="checkbox"/> MRI HEART W/I<br><input type="checkbox"/> MRI HEART VELOCITY FLOW MAP  | <input type="checkbox"/> CTX HEART W/O<br><input type="checkbox"/> CTX HEART CALCIUM SCORING   |   |                              |
| <b>X-RAY</b>  | <input type="checkbox"/> X-RAY<br><input type="checkbox"/> FLUOROSCOPY<br><input type="checkbox"/> DIGITAL SUBTRACTION   | <input type="checkbox"/> SKULL<br><input type="checkbox"/> CERVICAL<br><input type="checkbox"/> CHEST<br><input type="checkbox"/> LUNG  | <input type="checkbox"/> LUMBAR<br><input type="checkbox"/> THORACIC<br><input type="checkbox"/> PELVIS<br><input type="checkbox"/> ANKLE<br><input type="checkbox"/> WRIST<br><input type="checkbox"/> HAND | <input type="checkbox"/> SE<br><input type="checkbox"/> SE<br><input type="checkbox"/> CISTNOGRAM | - See Back of Order for Page |
| <b>US</b>   | <input type="checkbox"/> PELVIC (WITH TRANS VAG IF NECESSARY)<br><input type="checkbox"/> ABDOMEN<br><input type="checkbox"/> PROSTATE<br><input type="checkbox"/> COLOR DOPPLER<br><input type="checkbox"/> EXTREMITY<br><input type="checkbox"/> OTHER | <input type="checkbox"/> TESTICULAR (WITH COLOR FLOW IF NECESSARY)<br><input type="checkbox"/> BLADDER<br><input type="checkbox"/> TONGUE<br><input type="checkbox"/> DOPPLER<br><input type="checkbox"/> OTHER | <input type="checkbox"/> RENAL ARTERY<br><input type="checkbox"/> RENAL VEIN<br><input type="checkbox"/> BILATERAL<br><input type="checkbox"/> UNILATERAL<br><input type="checkbox"/> OTHER                  |   |                              |
| <b>CT</b>   | <input type="checkbox"/> HEAD<br><input type="checkbox"/> NECK<br><input type="checkbox"/> CHEST<br><input type="checkbox"/> ABDOMEN<br><input type="checkbox"/> OTHER   | <input type="checkbox"/> PELVIS<br><input type="checkbox"/> LUMBAR<br><input type="checkbox"/> THORACIC<br><input type="checkbox"/> OTHER   | <input type="checkbox"/> CTX<br><input type="checkbox"/> ABDOMEN<br><input type="checkbox"/> EXTREMITY<br><input type="checkbox"/> OTHER   |   |                              |
| <b>NUCLEAR</b>  | <input type="checkbox"/> BONE (WITH TOTAL BODY IF NECESSARY)<br><input type="checkbox"/> BONE (WITH TOTAL BODY IF NECESSARY)<br><input type="checkbox"/> BONE (WITH TOTAL BODY IF NECESSARY)   | <input type="checkbox"/> BONE (WITH TOTAL BODY IF NECESSARY)<br><input type="checkbox"/> BONE (WITH TOTAL BODY IF NECESSARY)<br><input type="checkbox"/> BONE (WITH TOTAL BODY IF NECESSARY)                    |  |   |                              |
| <b>BI-RADS</b>  | <input type="checkbox"/> BI-RADS (WITH TOTAL BODY IF NECESSARY)<br><input type="checkbox"/> BI-RADS (WITH TOTAL BODY IF NECESSARY)<br><input type="checkbox"/> BI-RADS (WITH TOTAL BODY IF NECESSARY)  |   |  |   |                              |
| PROCEDURE: <input type="checkbox"/> CYTOSPIN<br><input type="checkbox"/> BRUSH<br><input type="checkbox"/> BIOPSY<br><input type="checkbox"/> OTHER   |  |   |  |   |                              |
| PROVIDER SIGNATURE: _____ DATE: _____<br>SIGNATURE STAMPS ARE NOT VALID   |  |   |  |   |                              |

Spec Info: ASAP