



BAY REGION

# OUTPATIENT RADIOLOGY ORDER FORM

Appointment Date: \_\_\_\_\_

Appointment Time: \_\_\_\_\_

DOING WHAT'S BEST.

McLaren Bay Region Central Scheduling • Ph:1-800-McLaren • Fax:989-894-6143

PATIENT INFORMATION	Patient Name: _____ DOB: _____
	Height: _____ Weight: _____ Patient Phone: _____
	INSURANCE _____ PRE-AUTHORIZATION NUMBER: _____
	<b>DIAGNOSIS / REASON FOR EXAM(PLEASE INCLUDE LATERALITY; SPECIFIC SITE):</b> _____
	ORDERING PROVIDER (PRINT NAME): _____ OFFICE CONTACT: _____

MAMM	<input type="checkbox"/> SCREENING <input type="checkbox"/> BONE DENSITY	PET	<input type="checkbox"/> INITIAL STAGING <input type="checkbox"/> SUBSEQUENT
	<input type="checkbox"/> DIAGNOSTIC		<input type="checkbox"/> SKULL TO MID-THIGH <input type="checkbox"/> WHOLE BODY (MELANOMA)
	<input type="checkbox"/> UNILATERAL <input type="checkbox"/> BILATERAL		<input type="checkbox"/> MYOCARDIAL VIABILITY <input type="checkbox"/> BRAIN – ALZHEIMERS/DEMENTIA
	<input type="checkbox"/> LT <input type="checkbox"/> RT		<input type="checkbox"/> NAF BONE SCAN <input type="checkbox"/> GALLIUM GA 68-DOTATATE

X-RAY	<b>X-RAY</b> _____
	<b>FLUOROSCOPY</b> <input type="checkbox"/> BARIUM SWALLOW <input type="checkbox"/> UGI <input type="checkbox"/> SB <input type="checkbox"/> BE <i>See back of order for Prep</i> <input type="checkbox"/> VIDEO ESOPH <input type="checkbox"/> IVP <input type="checkbox"/> VCUG <input type="checkbox"/> CYSTOGRAM

US	<input type="checkbox"/> PELVIC (WITH TRANS VAG IF NECESSARY) <input type="checkbox"/> ABDOMEN <input type="checkbox"/> RENAL/KIDNEY <input type="checkbox"/> BLADDER
	<input type="checkbox"/> TESTICLE (WITH COLOR FLOW IF NECESSARY) <input type="checkbox"/> GB/LIVER <input type="checkbox"/> RENAL ARTERY <input type="checkbox"/> PROSTATE
	<input type="checkbox"/> THYROID <input type="checkbox"/> BREAST <input type="checkbox"/> BREAST LOCALIZER <input type="checkbox"/> OTHER: _____
	<input type="checkbox"/> SCROTUM <input type="checkbox"/> ABI OR PPG <input type="checkbox"/> SEGMENTAL PRESSURE <input type="checkbox"/> HEMODIALYSIS PRESSURE
	<input type="checkbox"/> <b>COLOR DOPPLER</b> <input type="checkbox"/> AORTA <input type="checkbox"/> VENOUS <input type="checkbox"/> CAROTIDS ARTERIAL (COLOR FLOW IF NECESSARY)
	<input type="checkbox"/> <b>OB</b> <input type="checkbox"/> EDD <input type="checkbox"/> LESS THAN 14 WEEKS <input type="checkbox"/> MORE THAN 14 WEEKS <input type="checkbox"/> LIMITED <input type="checkbox"/> BIOPHYSICAL

CT	<input type="checkbox"/> HEAD <input type="checkbox"/> CHEST <input type="checkbox"/> PELVIS <input type="checkbox"/> C-SPINE	CTA	<input type="checkbox"/> ABDOMEN <input type="checkbox"/> ABDOMEN/PELVIS
	<input type="checkbox"/> ABD/PEL <input type="checkbox"/> SINUS <input type="checkbox"/> ST NECK <input type="checkbox"/> T-SPINE		<input type="checkbox"/> CAROTID <input type="checkbox"/> HEAD <input type="checkbox"/> CHEST
	<input type="checkbox"/> ABDOMEN <input type="checkbox"/> CH/ABD/PEL <input type="checkbox"/> FACIAL <input type="checkbox"/> L-SPINE		<input type="checkbox"/> EXTREMITY <input type="checkbox"/> UPPER <input type="checkbox"/> LOWER <input type="checkbox"/> L <input type="checkbox"/> R
	<input type="checkbox"/> EXTREMITY <input type="checkbox"/> UPPER <input type="checkbox"/> LOWER <input type="checkbox"/> LT <input type="checkbox"/> RT		<input type="checkbox"/> AORTA W/RUNOFF
	<input type="checkbox"/> RENAL STONE <input type="checkbox"/> OTHER: _____		<input type="checkbox"/> OTHER: _____

NUC	<input type="checkbox"/> 3 PHASE BONE <input type="checkbox"/> TOTAL BODY BONE <input type="checkbox"/> V/Q SCAN <input type="checkbox"/> MUGA
	<input type="checkbox"/> SENTINEL NODE <input type="checkbox"/> THYROID UPTAKE <input type="checkbox"/> PARATHYROID <input type="checkbox"/> GASTRIC EMPYTING
	<input type="checkbox"/> HIDA SCAN <input type="checkbox"/> RENAL (WITH LASIX) <input type="checkbox"/> RENAL (WITHOUT LASIX) <input type="checkbox"/> MYOCARDIAL SPECT

MRI	<input type="checkbox"/> LUMBAR <input type="checkbox"/> BRAIN <input type="checkbox"/> BRAIN STEALTH <input type="checkbox"/> BREAST <input type="checkbox"/> CERVICAL
	<input type="checkbox"/> ABDOMEN <input type="checkbox"/> MRCP <input type="checkbox"/> PELVIS <input type="checkbox"/> THORACIC <input type="checkbox"/> ORBIT/FACE/NECK
	<input type="checkbox"/> EXTREMITY <input type="checkbox"/> UPPER <input type="checkbox"/> LOWER <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> MRA/HEAD/COW <input type="checkbox"/> MRA NECK/CAROTID

<b>PROCEDURES</b>
<input type="checkbox"/> MYELOGRAM <input type="checkbox"/> LUMBAR PUNCTURE <input type="checkbox"/> ARTHROGRAM <input type="checkbox"/> HYSTEROSALPINGOGRAM <input type="checkbox"/> BIOPSY/ASPIRATION

Contrast 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.: x-rays for an abnormal bone scan.) Signing this form indicates your agreement of the above.

TELEPHONE REPORT # \_\_\_\_\_

PROVIDER SIGNATURE (signature stamps are not valid) \_\_\_\_\_

DATE \_\_\_\_\_

TIME \_\_\_\_\_



100A

**OUTPATIENT  
RADIOLOGY  
ORDER FORM**

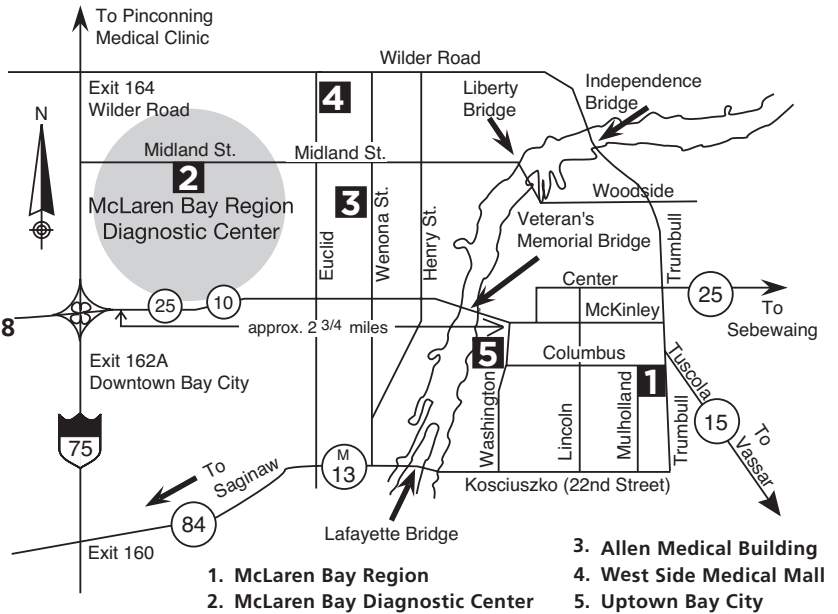
ADDRESSOGRAPH



## BAY REGION

DOING WHAT'S BEST.

- McLaren Bay Region,**  
1900 Columbus Avenue, Bay City MI, 48708  
**X-Ray, CT, Ultrasound, NM, PET, and MRI**
- McLaren Bay Diagnostic Center,**  
3175 W. Professional Drive, Bay City, MI 48706  
**Ultrasound, Bone Density, and Mammography**
- Diagnostic Imaging – West Side Medical Mall,**  
4175 N. Euclid, Bay City, MI 48706  
**CT and X-Ray**
- Diagnostic Imaging – Uptown Bay City,**  
4 Columbus Avenue, Suite 120, Bay City, MI 48708  
**X-Ray**
- McLaren Bay Region – Midland**  
801 Joe Mann Boulevard, Midland, MI 48642  
**X-Ray and Ultrasound**
- McLaren Bay Region – West Branch**  
2110 M-76, West Branch, MI 48661  
**X-Ray, CT, Ultrasound, NM, MRI,**  
**Mammography, and Bone Density**



### PATIENT INSTRUCTIONS:

Please bring your order form, photo ID, medical insurance card(s) and any previous related exams (not completed at McLaren facility) to your appointment.

### EXAM PREPARATIONS:

#### Barium Enema

##### Day before the exam:

1. One 8 oz. glass of water every 2 hrs.
2. Clear liquids all day (NO Dairy).
3. Following the clear liquid lunch, the patient shall drink on chilled 10 oz. bottle of Magnesium Citrate.
4. At 1:00 pm and 3:00 pm, the patient shall drink one chilled 10 oz. bottle of Magnesium Citrate.
5. At 1:00 pm and 3:00 pm, drink an 8 oz. glass of cold water.
6. At 4:00 pm, ingest Dulcolax laxatives.
7. Clear liquid supper (NO Dairy).
8. At bedtime, drink 8 oz. cold water.
9. Nothing to eat or drink after midnight.

#### IVP

##### Day before the exam:

1. Clear liquid lunch/supper.
2. At 5:00 pm, ingest 3 Dulcolax laxatives.
3. Nothing to eat or drink after midnight.

#### Upper GI, Barium Swallow, and/or Small Bowel Exam

##### Day before the exam:

1. Clear liquid supper.
2. Nothing to eat or drink after midnight.
3. No gum chewing.

#### Myelogram, Lumbar Puncture, or Arthrogram

1. Nothing to eat or drink after midnight day before.
2. No blood thinners 5 days prior.
3. Must have driver (Myelogram and LP).

#### Ultrasound

- Pelvis and OB** – Must finish 4 - 6 8 oz. glasses of fluid 1 hr. before appointment. Do not urinate. Your bladder must be very full.
- Abdomen (Aorta, GB & Kidney)** – Nothing to eat or drink for 8 hours prior to the exam.

#### CT

- Abdomen & Pelvis** – Nothing to eat for 4 hours prior to the exam. Based on diagnosis, you may be required to drink Barium for 1 1/2 hours prior to imaging.

#### Nuclear Medicine

- Myocardial** – Nothing to eat or drink 4 hours before the exam and NO caffeine (any form) for 12 hours before the exam. Please check with your physician regarding any medications to be withheld.
- HIDA Scan** – Nothing to eat or drink 4 hours before the exam, no opiate based pain medications 4 hours before the exam, eat a fatty snack (milk, ice cream, fried foods, meats, etc.) the evening before the exam.
- Gastric Emptying** – Nothing to eat or drink 8 hours before the exam.
- Renal Scan** – The patient should arrive well hydrated from the exam (drink extra fluids).
- Renal Scan with Lasix** – The patient should arrive well hydrated from the exam (drink extra fluids). Diuretics should not be taken the morning of the exam.
- Thyroid** – Nothing to eat or drink 4 hours before the first visit on the first day of the exam. No thyroid medications for 6 weeks prior. No compounds or medications containing IODINE in any form shall be taken 6 weeks prior, this includes IV contrast. No multivitamins for 2 weeks prior, no Cytomel 3 weeks prior, no Estrogens 3 weeks prior, and antihistamines shall be withheld for 1 week prior unless they contain iodine in which case they shall be withheld for 6 weeks.