

McLaren Print System Order

Order No: 85527
Order Date: 2024-05-15
Order Request Date:
User: Nick VanHorn
Phone: 989-894-6458

Ship Location: McLaren Bay Region Marketing Att: Nick VanHorn
300 Mulholland Ave Ste
Bay City, 48708

Brochures
Quantity: 500
Paragon Dept No: 10000 642840 - 1000
Dept Name: Marketing
Company Number:

Order Total Price: 80.50

Item Number: BAY-168 (XR-2140)
Item Description: OUTPATIENT RADIOLOGY ORDER Form
Revision Date: 03/2024
Print: 2 sided full color
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish: None
Drill: None
Poster:
Misc Info: 8.5x11 Color DS

McLaren **OUTPATIENT RADIOLOGY ORDER FORM** Appointment Date: _____
 SBT REGION Appointment Time: _____
 DR. KING WOODS JR. MD. McLaren Bay Region Central Scheduling, P.O. 1400-0436, Bay City, MI 48708-0436

Patient Name: _____ DOB: _____
 Height: _____ Weight: _____ Patient Phone: _____
 INSURANCE: _____ PID/AUTHORIZATION NUMBER: _____
 DIAGNOSIS/REASON FOR EXAM/PLEASE INCLUDE LATERALITY, IMPROV. SITE: _____
 ORDERING PROVIDER (PRINT NAME): _____ OFFICE CONTACT: _____

MAMMO SCREENING BONE DENSITY INITIAL STAGING SURVEILLANT
 DIAGNOSTIC BILATERAL SKULL TO MID THIGH WHOLE BODY (SHELVING)
 UNILATERAL PET FOCAL/AXIAL VENTRAL BRAIN - FLUORINE/SCANDIUM
 LT RT NAV BONE SCAN GALLIUM 67Ga-CITRATES

X-RAY FLUOROSCOPY BARIUM SWALLOW UGI MR BI See back of order for Prep
 MICRO ESOPH AP VOID CYSTOGRAM

US PELVIC (WITH TRANS VAG IF NECESSARY) ABDOMEN RENAL/KIDNEY BLADDER
 TESTICLE (WITH COLOR FLOW IF NECESSARY) GB/GALLBL RENAL ARTERY PROSTATE
 THYROID BREAST BREAST LOCALIZER OTHER _____
 SCROTUM AN OR PHS SERUM/PLASMA PRESSURE HEMODIALYSIS PRESSURE
 COLOR DOPPLER AORTA VENOUS CARDIO/ARTORIAL (COLOR FLOW IF NECESSARY)
 OB ECO LESS THAN 14 WEEKS MORE THAN 14 WEEKS LIMITED BICHOUSICAL

CT HEAD CHEST PELVIS C-SPINE CT A ABDOMEN ABDOMEN/PELVIS
 ANGIO SPINE ST NECK T-SPINE CERVICAL CERVICAL HEAD CHEST
 ABDOMEN CHEST/PELVIS SACRAL C-SPINE EXTREMITY UPPER LOWER RT LT RT LT
 RENAL STONE OTHER _____ OTHER _____

NUC 3-PHASE BONE TOTAL BODY BONE VQ SCAN MUGA
 SENTINEL NODE THYROID UPTAKE FNA/THYROID GASTRIC EMPTYING
 HEAD SCAN RENAL (WITH/LASER) RENAL (WITHOUT LASER) MYOCARDIAL PERF

MRI LUMBAR BRAIN BRAIN (WITH/TH) BREAST CERVICAL
 ABDOMEN MRCP PELVIS THORACIC CHEST/PELVIS
 EXTREMITY UPPER LOWER RT LT MR/HEAD/NOSE MR/NECK/CARDIAC

PROCEDURES MYOLOGRAM LUMBAR PUNCTURE ARTHROGRAM HYSTERO/SALPINGOGRAM BOP/SALPINGOGRAM

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TELEPHONE REPORT # _____ PROVIDER SIGNATURE (signature number on file) _____ DATE _____ TIME _____

Spec info: 10GA OUTPATIENT RADIOLOGY ORDER FORM

McLaren Bay Region Central Scheduling