

McLaren Print System Order

Order No: 88825
 Order Date: 2024-10-09
 User: Jodi Peterman
 Phone: 3422133

Ship Location: Jodi Peterman - McLaren Flint MRI Ballenger
 750 S Ballenger Hwy
 Flint, MI 48532

Forms
 Quantity: 18
 Paragon Dept No: 32113
 Dept Name: McLaren Flint MRI Ballenger
 Company Number: 60

Order Total Price: 235.80

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.
 e. BW

McLaren FLINT		OUTPATIENT RADIOLOGY ORDER FORM		Appointment Date _____
				Appointment Time _____
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 _____		
MRI	<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	
X-RAY	<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"/> RT <input type="checkbox"/> SS <input type="checkbox"/> VCUG <input type="checkbox"/> CISTOGRAM	<input type="checkbox"/> SE <input type="checkbox"/> SE	- 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 (MR)	<input type="checkbox"/> TESTICLE (WITH COLOR FLOW IF NECESSARY) <input type="checkbox"/> BLADDER <input type="checkbox"/> TENDON <input type="checkbox"/> DUCTS <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)	
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"/> ABDOMEN/PELVIS <input type="checkbox"/> EXTREMITY <input type="checkbox"/> EXTREMITY (MR)	<input type="checkbox"/> HEAD <input type="checkbox"/> SPINE <input type="checkbox"/> LOWER EXT <input type="checkbox"/> CHEST <input type="checkbox"/> OTHER
BONE	<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"/> OTHER	<input type="checkbox"/> LEUKOCYTE SCANS (BONE MARRON)	
BREAST	<input type="checkbox"/> MAMMOGRAPHY (WITH OR WITHOUT BIOPSY) (SEE PREVIOUS MAMMOGRAMS) <input type="checkbox"/> MAMMOGRAPHY (WITH OR WITHOUT BIOPSY) (BILATERAL) <input type="checkbox"/> MAMMOGRAPHY (WITH OR WITHOUT BIOPSY) (LEFT) <input type="checkbox"/> MAMMOGRAPHY (WITH OR WITHOUT BIOPSY) (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			
PROCEDURE	<input type="checkbox"/> CYST ASPIRATION <input type="checkbox"/> BREAST BI <input type="checkbox"/> MFLUORAM <input type="checkbox"/> OTHER	<input type="checkbox"/> SALICITIN <input type="checkbox"/> US-LONE <input type="checkbox"/> NEEDLE ASP BX	<input type="checkbox"/> LUMBAR PUNCTURE <input type="checkbox"/> MYELOGRAM <input type="checkbox"/> PAIN MANAGEMENT	<input type="checkbox"/> ARTHROGRAM
<input type="checkbox"/> TELEPHONE REPORT (Please Print) _____ <input type="checkbox"/> TELEPHONE REPORT (Please Print) _____		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: