McLaren Business Products

McLaren Print System Order

Order No: 90299
Order Date: 2024-11-22
User: Lisa Tilley
Phone: 586-493-8041

Ship Location: McLaren Macomb/Diagnostic Imaging
1000 Harrington
Mount Clemens, MI 48043
Form
Quantity: 500
Paragon Dept No: 27245
Dept Name: Diagnostic Imaging
Company Number:

Order Total Price: 68.00

Item Number: MAC-15 (221084)
Item Description: Physician Order Form Radiology
Revision Date: 10/2023
Print: 1 sided full color
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish: None
Drill: None
Poster:
Misc Info: 8.5x11 Color SS

Spec Info:

MACOMB
Diagnostic Imaging Department - RADIOLOGY
1000 Harrington Boulevard
Mount Clemens, MI 48043

PLEASE ARRIVE 15 MINUTES PRIOR TO APPOINTMENT TIME

Today's Date: ____

PHYSICIAN ORDER FORM – RADIOLOGY SERVICES

NAME: ____ BIRTHDATE: ____
Home Phone Number: ____ Cell Phone Number: ____
APPOINTMENT DATE: ____ TIME: ____
REFERRING PHYSICIAN: ____ Physician Phone Number: ____
Physician Signature (REQUIRED): ____ Fax Number: ____

ROUTINE RADIOLOGY EXAMS

CHECK EXAM TO BE PERFORMED WITH APPROPRIATE REASON / ICD-10 CODE

ABDOMEN	CHEST
☐ One View Abdomen	☐ Chest, Single PA/AP
☐ Flat/Upright Abdomen	☐ PA & Lateral Chest
☐ KUB (Flat Abdomen)	☐ Ribs, w/PA Chest ☐ Left ☐ Right
☐ Acute Abdomen w/PA Chest	☐ Bilateral Ribs w/PA Chest

Unlisted Exam/Special Instructions: ____
REASON FOR EXAM/DIAGNOSIS REQUIRED ____ ICD-10: ____
CLINICAL HISTORY Relevant Signs/Symptoms REQUIRED ____

HEAD AND NECK	SPINE AND PELVIS
☐ Eye for Foreign Body	☐ Cervical Spine with Flexion & Extension views
☐ Facial Bones	☐ Lumbosacral Spine w/Obliques
☐ Nasal Bones	☐ Thoracic (Dorsal) Spine- AP, Lateral, Swimmers
☐ Neck for Soft Tissue	☐ Pelvis
☐ Sinuses-Paranasal 3 views	☐ Sacrum, Coccyx
☐ Skull, Complete	☐ Sacroiliac (SI) Joints
	☐ Scoliosis Survey, Standing

Unlisted Exam/Special Instructions: ____
REASON FOR EXAM/DIAGNOSIS REQUIRED ____ ICD-10: ____
CLINICAL HISTORY Relevant Signs/Symptoms REQUIRED ____

LOWER EXTREMITY	UPPER EXTREMITY
☐ Ankle- 3 view ☐ Left ☐ Right	☐ Ac Joints, Bilateral
☐ Femur ☐ Left ☐ Right	☐ Elbow- 3 view ☐ Left ☐ Right
☐ Foot- 3 view ☐ Left ☐ Right	☐ Fingers ☐ Left ☐ Right
☐ Hip ☐ Left ☐ Right	☐ Forearm ☐ Left ☐ Right
☐ Knee- 3 view ☐ Left ☐ Right	☐ Hand- 3 view ☐ Left ☐ Right
☐ Os Calcis ☐ Left ☐ Right	☐ Humerus ☐ Left ☐ Right
☐ Tibia/Fibula ☐ Left ☐ Right	☐ Scapula ☐ Left ☐ Right
☐ Toe ☐ Left ☐ Right	☐ Shoulder ☐ Left ☐ Right
☐ Other ____ ☐ Left ☐ Right	☐ Wrist- 3 view ☐ Left ☐ Right

Unlisted Exam/Special Instructions: ____
REASON FOR EXAM/DIAGNOSIS REQUIRED ____ ICD-10: ____
For Fracture indicate the following: ☐ Initial ☐ Subsequent ☐ Routine ☐ Delayed Healing
CLINICAL HISTORY Relevant Signs/Symptoms REQUIRED ____