CR CLERMONT RADIOLOGY

Patient Name: ____________________ DOB: __________

Patient Phone: ____________________

Diagnosis: ____________________

☐ Report only ☐ CD ☐ Portal

MRI

☐ Brain
☐ IACs
☐ Pituitary
☐ Orbits
☐ C-Spine
☐ T-Spine
☐ L-Spine
☐ Soft Tissue Neck
☐ Abdomen
☐ Pelvis
☐ Shoulder ☐ L ☐ R
☐ Elbow ☐ L ☐ R
☐ Wrist ☐ L ☐ R
☐ Hand ☐ L ☐ R
☐ Hip ☐ L ☐ R
☐ Knee ☐ L ☐ R
☐ Ankle ☐ L ☐ R
☐ Foot ☐ L ☐ R
☐ Other ____________________

Arthrography

☐ Hip ☐ L ☐ R
☐ Wrist ☐ L ☐ R
☐ Shoulder ☐ L ☐ R
☐ Knee ☐ L ☐ R
☐ Other (Please Specify) ____________________

X-Ray

☐ C-Spine
☐ T-Spine
☐ L-Spine
☐ Scoliosis
☐ Pelvis
☐ Chest
☐ KUB
☐ Skull
☐ Facial
☐ Orbits
☐ Sinus
☐ SI Joints
☐ Bone Age
☐ Finger (Digit)________ ☐ L ☐ R
☐ Toe (Digit)________ ☐ L ☐ R
☐ Soft Tissue Neck
☐ Abdomen w/ Upright
☐ Sacrum/Coccyx
☐ Other ____________________

☐ Shoulder ☐ L ☐ R
☐ Humerus ☐ L ☐ R
☐ Elbow ☐ L ☐ R
☐ Forearm ☐ L ☐ R
☐ Wrist ☐ L ☐ R
☐ Hand ☐ L ☐ R
☐ Ribs ☐ L ☐ R
☐ Hip ☐ L ☐ R
☐ Femur ☐ L ☐ R
☐ Knee ☐ L ☐ R
☐ Tib/Fib ☐ L ☐ R
☐ Ankle ☐ L ☐ R
☐ Foot ☐ L ☐ R

Bone Densitometry

☐ DEXA Scan
☐ Body Composition

Contrast

☐ Without ☐ With ☐ Without/With

MRA

☐ Head (COW) — w/o contrast is routine
☐ Carotid — Contrast optional
☐ Other ____________________

Upright Protocols

☐ Cervical ☐ Flex. ☐ Ext. ☐ ALAR
☐ Thoracic
☐ Lumbar ☐ Flex. ☐ Ext.
☐ Other (Please Specify) ____________________

CT Scan

☐ Brain
☐ Sinuses
☐ Neck
☐ Chest
☐ Cervical Spine
☐ Thoracic Spine
☐ Lumbar Spine
☐ Abdomen
☐ Pelvis
☐ Abdomen and Pelvis
☐ Other: ____________________

☐ Oral Contrast
☐ IV Contrast

If patient is over 60, diabetic, or has high blood pressure current Creatinine/BUN is required

☐ Without
☐ With
☐ Without & With

Ultrasound

☐ Abdomen
☐ RUQ (GB, Liver)
☐ Renal
☐ Renal Artery Doppler
☐ Scrotal
☐ Pelvis (Transabdominal)
☐ Pelvis (Transvaginal)
☐ Thyroid
☐ Arterial Imaging ☐ Upper ☐ Lower ☐ L ☐ R
☐ Venous Doppler ☐ Upper ☐ Lower ☐ L ☐ R
☐ OB ________ Trimester
☐ Echo
☐ Breast ☐ L ☐ R
☐ Carotid Doppler
☐ Soft Tissue Non-Vascular (Please Specify Location) ____________________
☐ Other ____________________

Mammography

☐ Screening (Bilateral)
☐ Diagonostic ☐ Bilateral ☐ L ☐ R
☐ Include Ultrasound ☐ Bilateral ☐ L ☐ R

CTA

☐ Head
☐ Neck
☐ Chest
☐ Abdomen
☐ Abdomen and Pelvis
☐ Abdomen and Pelvis w/ Runoff

Nuclear Medicine

☐ Bone Scan
☐ 3 Phase Bone Scan
☐ Gastric Emptying
☐ HIDA Scan
☐ Thyroid Uptake & Scan
☐ Liver/Spleen Scan
☐ MUGA
☐ First Pass MUGA
☐ Renal Function
☐ Renal Function w/ Lasix
☐ Renal Function w/ Captopril
☐ Parathyroid
☐ Quantitative Lung Scan
☐ Salivary Gland Scan
☐ Testicular Scan
☐ DaT Scan
☐ HIDA w/CCK
☐ Other ____________________

PET/CT

☐ FDG Oncology PET (Eyes to Thighs)
☐ FDG Oncology PET (Whole Body - Melanoma)
☐ F-18 NaF Bone
☐ Cardiac Viability
☐ Other: ____________________

Physician Name: ____________________ Physician Phone: __________

Physician Signature: ____________________ Date: __________