

# ORDERS: IMAGING REQUISITION FORM

Diagnostic Imaging Department Hours: Monday - Friday 8:00 - 6:00 pm Scheduling 907-714-4420 Fax 907-714-4957

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Physician Signature: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Today's Date: \_\_\_\_\_

<input type="checkbox"/> ROUTINE
<input type="checkbox"/> EXPEDITED work into schedule ASAP
<input type="checkbox"/> EMERGENT hold patient <small>Provider cell phone/pager</small>

**Focus of Clinical Concern (signs/symptoms related to examination ordered):** \_\_\_\_\_

**ICD-10 CODE(S):** \_\_\_\_\_

Please avoid the phrase "rule out" or abbreviations

Additional copies to: \_\_\_\_\_

Sex: M F Pregnant: Y N Diabetic: Y N Allergies: \_\_\_\_\_

Fluoroscopy <i>(Soldotna only)</i>	Abdomen and pelvis	Extremities
*Barium enema	Abdomen - KUB	A.C. joints (bilateral)
*Barium swallow	Abdomen - complete	Ankle: <input type="checkbox"/> with stress R L
*Barium swallow (modified, speech path)	Acute abdomen series	Bone age
*Catheter patency study	Nose to rectum (pediatric)	Bone survey: <input type="checkbox"/> complete <input type="checkbox"/> pediatric
*Cystogram	Pelvis	Calcaneus R L
*Feeding tube placement/repositioning	*Transit time study	Clavicle R L
*Fistulogram	<b>Other:</b>	Elbow R L
*Hysterosalpingogram	<b>Spine</b>	Femur R L
*Joint injection/aspiration: <small>specify</small> R L		Finger: <small>specify</small> R L
*Lumbar puncture	Cervical spine <input type="checkbox"/> with obliques <input type="checkbox"/> 2-3 views (default) <input type="checkbox"/> with flex/ext	Foot <input type="checkbox"/> weight-bearing R L
*Retrograde urethrocytogram	Lumbar spine <input type="checkbox"/> with obliques <input type="checkbox"/> 2-3 views (default) <input type="checkbox"/> with flex/ext	Forearm R L
*Small bowel follow - through	Sacroiliac joints	Hand R L
*Upper GI series, with KUB	Sacrum & coccyx	Hip: <input type="checkbox"/> Pelvis & Hip (default) R L <input type="checkbox"/> Hip only R L
*Voiding cystourethrogram	Scoliosis study	Humerus R L
<b>Thorax</b>	Thoracic spine	Knee: <input type="checkbox"/> 1 -2 views R L <input type="checkbox"/> 3 views (default) <input type="checkbox"/> 4+ views <input type="checkbox"/> with AP standing bilateral view
	Thoracolumbar spine	Leg lengths
	<b>Other:</b>	
Chest 1 view	<b>Head &amp; Neck</b>	Scapula R L
Chest 2 views		Shoulder R L
Chest with apical lordotic		Tibia / fibula R L
Decubitus chest R L	Facial bones	Toe <small>specify</small> R L
Inspiratory & expiratory chest	Mandible	Wrist: <input type="checkbox"/> with scaphoid view R L
Ribs: <input type="checkbox"/> with PA chest R L	Nasal bones	<b>Other:</b>
Sternum	Neck soft tissues	<b>OTHER STUDIES</b>
<b>Other:</b>	Orbits	
	Sinuses	
	Skull	
	<b>Other:</b>	Bone mineral density <i>(Kenai Health Center Only)</i>

Please select the desired exam(s) by checking the left cell(s), and circle R and/or L as needed. Smaller check boxes represent available exam options. If these are not checked, the default or appropriate protocol will be selected by the radiologist/staff based upon the provided clinical information.

**\* Asterisk before a test indicates an appointment is necessary. Call 907-714-4420 to Schedule**

**Examination can not be performed without a valid (signed) order.**

**central peninsula hospital**  
 250 Hospital Place, Soldotna, AK 99669  
 (907) 714-4404 \* www.cpgh.org

Patient Label

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ULTRASOUND <i>(Soldotna only)</i>	CT SCAN <i>(Soldotna only)</i>	*Lower ext: _____ specify _____ R L
*Abdomen <input type="checkbox"/> <i>with limited duplex</i>	*Abdomen <input type="checkbox"/> <i>no IV contrast</i> <input type="checkbox"/> <i>adrenal</i>	*MR angiography: _____ specify _____
*Biopsy: _____ specify _____	<input type="checkbox"/> <i>liver</i> <input type="checkbox"/> <i>pancreas</i> <input type="checkbox"/> <i>renal</i>	*MR arthrogram: _____ R L
*Extremity non-vascular R L _____ specify _____	*Abdomen-pelvis <input type="checkbox"/> <i>no IV contrast</i>	_____ specify _____
*Fetal biophysical profile <input type="checkbox"/> <i>twins</i>	<input type="checkbox"/> <i>CT-KUB</i> <input type="checkbox"/> <i>CT-IVP</i>	*Neck
*Fine needle aspiration: _____ specify _____	*Biopsy: _____ specify _____	*Orbits
*Obstetric (1st trimester) <input type="checkbox"/> <i>twins</i>	*Chest <input type="checkbox"/> <i>no contrast</i> <input type="checkbox"/> <i>high resolution</i>	*Pelvis <input type="checkbox"/> <i>bony</i> <input type="checkbox"/> <i>soft tissue</i>
*Obstetric (2nd - 3rd trimester) <input type="checkbox"/> <i>twins</i> <input type="checkbox"/> <i>limited</i> _____ specify _____	*Chest-abdomen <input type="checkbox"/> <i>no IV contrast</i>	*Spine <input type="checkbox"/> <i>cervical</i> <input type="checkbox"/> <i>thoracic</i> <input type="checkbox"/> <i>lumbar</i>
*Pelvis <input type="checkbox"/> <i>transabdominal only</i>	*Chest-abdomen-pelvis <input type="checkbox"/> <i>no IV contrast</i>	*Stroke protocol: brain MR brain MRA, neck MRA
*Retroperitoneum <input type="checkbox"/> <i>kidneys/bladder only</i>	*CT angiography: _____ specify _____	*Temporomandibular joints
*Scrotal with limited duplex	<input type="checkbox"/> <i>pulmonary embolism protocol</i>	*Upper ext: _____ specify _____ R L
*Thyroid	<input type="checkbox"/> <i>dissection protocol (chest - abd)</i>	*Other: _____
*US guidance: _____ specify _____	<input type="checkbox"/> <i>peripheral runoff</i>	<b>NUCLEAR MEDICINE <i>(Soldotna only)</i></b>
*Other: _____	*Head <input type="checkbox"/> <i>with and without contrast</i>	*Bone scan <input type="checkbox"/> <i>whole body (default)</i>
<b>VASCULAR ULTRASOUND</b> <i>(Soldotna only)</i>	*Lower ext: _____ specify _____ R L	<input type="checkbox"/> <i>limited</i> <input type="checkbox"/> <i>3 phase</i> <input type="checkbox"/> <i>SPECT</i>
*Renal artery duplex:	*Maxillofacial	*Cardiac blood pool (MUGA)
*Ankle - brachial index	*Neck <input type="checkbox"/> <i>no contrast</i>	*Cardiac perfusion SPECT
*Aorta - iliac duplex	*Orbits <input type="checkbox"/> <i>no contrast</i>	*Gastric emptying
*Carotid duplex	*Pelvis <input type="checkbox"/> <i>no IV contrast</i> <input type="checkbox"/> <i>cystogram</i>	*G.I. blood loss
*Echocardiogram <input type="checkbox"/> <i>limited</i>	*Sinus	*Hepatobiliary scan (HIDA)
*Lower extremity arterial R L	*Temporal bones	*Infection localization
*Lower extremity venous R L	*Spine <input type="checkbox"/> <i>cervical</i> <input type="checkbox"/> <i>thoracic</i> <input type="checkbox"/> <i>lumbar</i>	<input type="checkbox"/> <i>whole body</i> <input type="checkbox"/> <i>limited</i> <input type="checkbox"/> <i>SPECT</i>
*Segmental blood pressures and volume plethysmography	<input type="checkbox"/> <i>CT myelogram</i>	*Intestine (Meckel's diverticulum)
*Upper extremity arterial R L	*Upper ext: _____ specify _____ R L	*Liver & spleen <input type="checkbox"/> <i>SPECT</i>
*Upper extremity venous R L	*Other: _____	*Parathyroid
*IVC with bilateral iliac veins	<b>*CT Lung Cancer Screening</b>	*Pulmonary perfusion/ventilation (VQ)
*Other: _____	Number of pack years: _____	*Renal flow/function <input type="checkbox"/> <i>+Lasix</i> <input type="checkbox"/> <i>+Captopril</i>
	Smoking Status: _____	*Sentinel lymph node injection
	Patient is asymptomatic: <input type="checkbox"/> Yes <input type="checkbox"/> No	*Thyroid with uptake <input type="checkbox"/> <i>without uptake</i>
	<b>MRI <i>(Soldotna only)</i></b>	*Other: _____
	*Abdomen <input type="checkbox"/> <i>liver</i> <input type="checkbox"/> <i>adrenal</i>	
	<input type="checkbox"/> <i>pancreas</i> <input type="checkbox"/> <i>MRCP</i>	
	*Abdomen-pelvis <input type="checkbox"/> <i>bowel</i> <input type="checkbox"/> <i>renal</i>	
	*Brain <input type="checkbox"/> <i>IAC</i> <input type="checkbox"/> <i>pituitary</i>	
	<input type="checkbox"/> <i>multiple sclerosis</i> <input type="checkbox"/> <i>seizures</i>	

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 RAD020 SP/PMR Rev. 12/03/15

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