Saint Alphonsus Medical Group
BAKER CITY

RADIOLOGY OUTPATIENT ORDERS

Scheduling: 541-524-7861 Fax: 541-524-7824

Patient Name (Required)	**DOB** (Required)	☐ M ☐ F	Patient Phone
Insurance Provider			**Diagnosis, Sign or Symptom (Narrative Required) No Codes:**
Preauthorization Number(s) per procedure *(CT/MRI Only)*			
Exam Date / /	Exam Time am/pm		CC:
☐ Call patient to schedule exam			Schedule by (date)
Contact Person at Office		Office Fax	**Office Phone** (Required)
Provider Name (Required)	**Provider Signature** (Required)		**Date/Time** (Required)

X-Ray

☐ Chest PA & Lat ☐ Chest PA only ☐ KUB ☐ Pelvis
☐ Cervical Spine – Complete ☐ Cervical Lateral Flex/Ext ☐ Cervical AP and Lat Flex/Ext ☐ Sacrum/Coccyx
☐ Thoracic Spine – Complete ☐ Lumbar – Dept protocol ☐ Lumbar Lateral Flex/Ext ☐ Lumbar with Obliques
☐ Other_____

Please specify:

☐ **Right** ☐ **Left** ☐ **Bilateral**
☐ AC Joints ☐ Ankle ☐ Clavicle
☐ Elbow ☐ Femur ☐ Finger _____
☐ Hand ☐ Foot ☐ Forearm
☐ Humerus ☐ Knee ☐ Hip
☐ Shoulder ☐ SI Joints ☐ OS Calcus
☐ Toe _____ ☐ Wrist ☐ Tibia/Fibula

Comment: _____

Scheduled General Diagnostic Procedures

☐ Arthrogram, Location: _____
☐ Barium Enema
☐ Cystogram
☐ Esophagram
☐ VCUG
☐ IVP
☐ Retrograde Urethrogram
☐ SBFT
☐ Other _____
☐ Upper GI
☐ Video Swallow Evaluation

Ultrasound

☐ Abdomen Only
☐ Abdominal Aorta
☐ Breast (right/left)
☐ Chest
☐ Soft tissue neck
☐ Thyroid/Parathyroid
☐ Transvaginal only
☐ Renal
☐ Abd Limited (RUQ/LUQ/RLQ/LLQ)
☐ Scrotal (w/ Duplex if indicated)
☐ OB < 14wks TA/TV
☐ Pelvic with transvaginal (w/ Duplex if indicated)
☐ OB > 14wks
☐ Aspirations/Biopsy/Drain: Type _____
☐ Color/Duplex: Venous _____ ☐ Right ☐ Left ☐ Bilateral
☐ Extremity Non Vascular _____ ☐ Right ☐ Left ☐ Bilateral
☐ Carotid artery
☐ Other _____

MRI Please Indicate: ☐MRI ☐MRA ☐Other:_____

Area to be Scanned:

Please check the following box(es) if the referring physician is willing to defer to the radiologist's judgment on whether the use of: ☐ Contrast is medically necessary ☐Orbital x-rays are medically necessary

Please check the following box if the referring physician is ordering blood work for contrast patients when medically necessary: ☐ BUN, Creatinine and GFR level – Evaluation for Renal Function prior to MRI contrast

CT

☐ **Per Radiologist discretion** ☐ **W/Contrast** ☐ **W/O Contrast**

☐ Abdomen w/Pelvis
☐ Abdomen Only
☐ CT IVP
☐ Chest
☐ High Resolution Chest
☐ Pelvis only
☐ Other _____
☐ Head/Brain
☐ Sinus / Maxillofacial
☐ Soft tissue neck
☐ **Myelogram**
☐ **Interventional Procedure**
☐ Biopsy _____
☐ Injection _____
☐ Aspiration/Drainage _____
☐ Cervical
☐ Thoracic
☐ Lumbar

Orthopedic

☐ **W/3D Reconstruction** ☐ **Left** ☐ **Right** ☐ **Bilateral** ☐ **Presurgical**

☐ Ankle ☐ Elbow ☐ Foot ☐ Hip ☐ Ortho Pelvis ☐ Knee ☐ Shoulder ☐ Wrist

CT Angiography (CTA)

☐ CTPA – Pulmonary
☐ CTA Abdominal Aorta thru Pelvis
☐ CTA Abdominal Aorta w/Runoff
☐ CTA Thoracic Aorta / Chest
☐ CTA Abdomen/Renal
☐ CTA Chest/Abdomen/Pelvis
☐ CTA Neck/Extra-cranial (Carotid)
☐ CTA Head/Intracranial (COW)

Please fax supporting documentation, such as worksheets or history and physical, to 541-524-7929.

* B K - 1 7 4 *