Saint Alphonsus
BOISE NAMPA ONTARIO BAKER CITY

RADIOLOGY OUTPATIENT ORDERS – SAHS-2372

Centralized Scheduling:
Boise/Nampa: 367-8787 Fax: 367-7788
Ontario: 541-881-7474 Fax: 541-881-7039

Patient Name	**DOB**	☐ M ☐ F	Patient Phone
Insurance Provider	**Diagnosis, Sign or Symptom (Narrative Required):**		
Preauthorization Number(s) per procedure			
Exam Date / /	Exam Time am/pm	CC:	
☐ Call patient to schedule exam	Schedule by (date)		
Contact Person at Office	Office Fax	**Office Phone**	
Provider Name	**Provider Signature**	**Date/Time**	

X-Ray

☐ Chest PA & Lat ☐ Chest PA only ☐ KUB ☐ Pelvis
☐ Cervical Spine – Complete ☐ Thoracic Spine – Complete ☐ Lumbar - Series ☐ Sacrum/Coccyx
☐ Cervical Lateral Flex/Ext ☐ Cervical AP and Lat Flex/Ext ☐ Lumbar Lateral Flex/Ext ☐ Lumbar with Obliques
☐ Lumbar AP/LAT/FLEX/EXT ☐ 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 ☐ Aorta Duplex ☐ Aorta Screening ☐ Breast (right/left) ☐ Breast Bilateral ☐ Chest ☐ Soft tissue neck ☐ Thyroid/Parathyroid ☐ Infant hips
☐ Abd Limited (RUQ/LUQ/RLQ/LLQ) ☐ Scrotal (w/ Duplex if indicated) ☐ OB < 14wks TA/TV (w/Duplex if indicated) ☐ OB > 14wks ☐ Pelvic w/ transvaginal (w/Duplex if indicated) ☐ w/ 3-D if indicated ☐ Transvaginal only(w/ Duplex if indicated) ☐ Renal
☐ Aspirations/Biopsy/Drain: Type _____
☐ Venous Duplex: ___Lower ___Upper Side: ___Right ___Left ___Bilateral
☐ Extremity ___Lower ___Upper Left / Right Side: ___Right ___Left
☐ Carotid artery Duplex ☐ Renal artery Duplex ☐ Other _____

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
☐ Spine(s): ☐ Myelogram ☐ Low-Dose ☐ Full-Dose
☐ Cervical ☐ Thoracic ☐ Lumbar
☐ Interventional Procedure ☐ Biopsy _____ ☐ Injection _____ ☐ Aspiration/Drainage _____

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 Neck/Extra-cranial (Carotid) ☐ CTA Head/Intracranial (COW)
☐ CTA Thoracic Aorta / Chest ☐ CTA Abdomen/Renal ☐ CTA Chest/Abdomen/Pelvis
☐ CTA Coronary ☐ Calcium Score

Nuclear Medicine

☐ Bone Scan Whole Body ☐ with _____SPECT ☐ Bone Scan 3 Phase ☐ Thyroid Uptake/Scan
☐ Bone Scan LMT w/SPECT ☐ ERPF-Renal ☐ Myocardial Perfusion Spect with Stress ☐ Gastric Emptying
☐ Gallbladder Quant ☐ Parathyroid Planar ☐ Regadenoson ☐ Sentinel Node
☐ w/ SPECT ☐ Treadmill ☐ Other_____
☐ Lung Scan ☐ Quant Lung Scan ☐ Dobutamine

Interventional Procedures (angiography, neuroradiology) – Please fax supporting documentation, such as worksheets or history and physical, to (208) 367-4022.
Mammography or DEXA – Refer to Breast/Dexa/OBGYN Outpatient Order Form, fax to Centralized Scheduling.
MRI at Saint Alphonsus - Call Intermountain Medical Imaging (IMI) at (208) 367-7522 to schedule.

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