



**RADIOLOGIC CONSULTATION
HH 522H MR**

**CT EXAMINATION HEAD,
NECK and SPINE**

- Inpatient
- Outpatient
- ED
- ICU

NAME
MEDICAL RECORD #:
BIRTHDATE
PCP:

AREA TO BE EXAMINED / TYPE OF EXAMINATION	SCHEDULED DATE:	FOR EMERGENCY CONSULTATIONS AFTER 4 PM MON. - FRI., SATURDAY, SUNDAY AND HOLIDAYS, FAX TO STRONG MEMORIAL RADIOLOGY (585) 506-0062
	FLOOR	
DIAGNOSIS OR CLINICAL SUSPICION (REQUIRED) <i>Rule out diagnosis not acceptable</i>	SEND PHYSICIAN'S PERSONAL COPY TO: NAME: _____ MD	
	FIRST LAST	
	ADDRESS	
	STREET CITY ZIP	
HISTORY / CLINICAL INFORMATION (REQUIRED)	CLINICIAN SIGNATURE ATTENDING/RESIDENT/NP/PA _____ RESIDENT _____ BEEPER _____	
PATIENT POTENTIALLY PREGNANT? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, LMP	FOR URGENT / EMERGENCY RESULTS MON. - FRI. AFTER 5 PM & WEEKENDS, PLEASE INCLUDE FAX #.	
BUN _____	Creatinine _____	PRECAUTIONS _____
FAX #:		

CHECK ALL THAT APPLY (REQUIRED) Diagnosis or Clinical Suspicion - Symptoms

HEAD CT / CTA	FACE CT	ORBIT CT	CERVICAL, THORACIC, LUMBAR SPINE CT
<input type="checkbox"/> Headache <input type="checkbox"/> Convulsions <input type="checkbox"/> Syncope and collapse <input type="checkbox"/> Cognitive deficits - altered level of consciousness <input type="checkbox"/> Aphasia <input type="checkbox"/> Other speech and language deficits <input type="checkbox"/> Hemiplegia / Hemiparesis <input type="checkbox"/> Dominant <input type="checkbox"/> Nondominant <input type="checkbox"/> Monoplegia, upper limb <input type="checkbox"/> Dominant <input type="checkbox"/> Nondominant <input type="checkbox"/> Monoplegia, lower limb <input type="checkbox"/> Dominant <input type="checkbox"/> Nondominant <input type="checkbox"/> Other paralytic syndrome <input type="checkbox"/> TIA <input type="checkbox"/> Impending CVA <input type="checkbox"/> Dementia <input type="checkbox"/> Psychosis / Delirium <input type="checkbox"/> Skull fracture <input type="checkbox"/> Post concussion syndrome <input type="checkbox"/> Anoxic brain damage <input type="checkbox"/> Hydrocephalus <input type="checkbox"/> Intracranial Abscess / Meningitis <input type="checkbox"/> Malignant neoplasm of brain Specify: _____ <input type="checkbox"/> Benign neoplasm of brain Specify: _____ <input type="checkbox"/> Subarachnoid hemorrhage <input type="checkbox"/> Cerebral laceration and contusion <input type="checkbox"/> Subarachnoid, subdural or extra-dural hemorrhage following injury <input type="checkbox"/> Congenital anomalies	<input type="checkbox"/> Injury of face and neck <input type="checkbox"/> Malignant neoplasm of face Specify: _____ <input type="checkbox"/> Benign neoplasm of face Specify: _____ <input type="checkbox"/> Acute sinusitis <input type="checkbox"/> Chronic sinusitis <input type="checkbox"/> Nasal polyps <input type="checkbox"/> Disturbance of salivary secretion <input type="checkbox"/> Jaw lesion <input type="checkbox"/> Temporomandibular joint disorder <input type="checkbox"/> Fracture Specify: _____	<input type="checkbox"/> Acute inflammation of orbit <input type="checkbox"/> Orbital edema or congestion <input type="checkbox"/> Ophthalmoplegia <input type="checkbox"/> Malignant neoplasm of orbit Specify: _____ <input type="checkbox"/> Benign neoplasm of orbit Specify: _____ <input type="checkbox"/> Congenital anomalies <input type="checkbox"/> Retinal disease <input type="checkbox"/> Choroidal disease	<input type="checkbox"/> Spinal cord injury <input type="checkbox"/> Fracture of vertebral column Specify: _____ <input type="checkbox"/> Compression of spinal nerve root <input type="checkbox"/> Sciatica <input type="checkbox"/> Spondylosis without myelopathy <input type="checkbox"/> Spondylosis with myelopathy <input type="checkbox"/> Disc displacement <input type="checkbox"/> Disc degeneration <input type="checkbox"/> Spinal stenosis <input type="checkbox"/> Post Laminectomy syndrome <input type="checkbox"/> Discitis <input type="checkbox"/> Osteomyelitis <input type="checkbox"/> Lumbar spondylolysis <input type="checkbox"/> Spondylolisthesis <input type="checkbox"/> Congenital anomalies <input type="checkbox"/> Malignant neoplasm Specify: _____ <input type="checkbox"/> Benign neoplasm Specify: _____
	TEMPORAL BONE CT	NECK CT/CTA	
	<input type="checkbox"/> Vertigo <input type="checkbox"/> Peripheral or <input type="checkbox"/> Central <input type="checkbox"/> Labyrinthitis <input type="checkbox"/> Tinnitus <input type="checkbox"/> Acute mastoiditis <input type="checkbox"/> Otitis media <input type="checkbox"/> Otitis externa <input type="checkbox"/> Cholesteatoma <input type="checkbox"/> Complication following mastoidectomy <input type="checkbox"/> Anomalies of ear causing impairment of hearing Specify: _____	<input type="checkbox"/> Enlargement of lymph nodes <input type="checkbox"/> Acute pharyngitis <input type="checkbox"/> Cellulitis or abscess of neck or oral soft tissue <input type="checkbox"/> Malignant neoplasm of neck Specify: _____ <input type="checkbox"/> Benign neoplasm of neck Specify: _____ <input type="checkbox"/> Paralysis of vocal cords or larynx <input type="checkbox"/> Fracture of larynx or trachea <input type="checkbox"/> Congenital anomalies Specify: _____ <input type="checkbox"/> Neck injury	DENTAL CT
			<input type="checkbox"/> Dentascan, Mandible <input type="checkbox"/> Dentascan, Maxilla <input type="checkbox"/> Maxilla CT view, SIM/Plant <input type="checkbox"/> Mandible CT view, SIM/Plant

Report or Film Requests: (585) 341-6785
CT Exam Scheduling: (585) 341-6785
CT FAX #: (585) 341-8204

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HEAD CT / CTA	FACE CT	ORBIT CT	CERVICAL, THORACIC, LUMBAR SPINE CT
<input type="checkbox"/> Headache	<input type="checkbox"/> Injury of face and neck	<input type="checkbox"/> Acute inflammation of orbit	<input type="checkbox"/> Spinal cord injury
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Malignant neoplasm of face Specify: _____	<input type="checkbox"/> Orbital edema or congestion	<input type="checkbox"/> Fracture of vertebral column
<input type="checkbox"/> Syncope and collapse	<input type="checkbox"/> Benign neoplasm of face Specify: _____	<input type="checkbox"/> Ophthalmoplegia	<input type="checkbox"/> Specify: _____
<input type="checkbox"/> Cognitive deficits - altered level of consciousness	<input type="checkbox"/> Acute sinusitis	<input type="checkbox"/> Malignant neoplasm of orbit Specify: _____	<input type="checkbox"/> Compression of spinal nerve root
<input type="checkbox"/> Aphasia	<input type="checkbox"/> Chronic sinusitis	<input type="checkbox"/> Benign neoplasm of orbit Specify: _____	<input type="checkbox"/> Sciatica
<input type="checkbox"/> Other speech and language deficits	<input type="checkbox"/> Nasal polyps	<input type="checkbox"/> Congenital anomalies	<input type="checkbox"/> Spondylosis without myelopathy
<input type="checkbox"/> Hemiplegia / Hemiparesis <input type="checkbox"/> Dominant <input type="checkbox"/> Nondominant	<input type="checkbox"/> Disturbance of salivary secretion	<input type="checkbox"/> Retinal disease	<input type="checkbox"/> Spondylosis with myelopathy
<input type="checkbox"/> Monoplegia, upper limb <input type="checkbox"/> Dominant <input type="checkbox"/> Nondominant	<input type="checkbox"/> Jaw lesion	<input type="checkbox"/> Choroidal disease	<input type="checkbox"/> Disc displacement
<input type="checkbox"/> Monoplegia, lower limb <input type="checkbox"/> Dominant <input type="checkbox"/> Nondominant	<input type="checkbox"/> Temporomandibular joint disorder		<input type="checkbox"/> Disc degeneration
<input type="checkbox"/> Other paralytic syndrome	<input type="checkbox"/> Fracture Specify: _____		<input type="checkbox"/> Spinal stenosis
<input type="checkbox"/> TIA			<input type="checkbox"/> Post Laminectomy syndrome
<input type="checkbox"/> Impending CVA			<input type="checkbox"/> Discitis
<input type="checkbox"/> Dementia			<input type="checkbox"/> Osteomyelitis
<input type="checkbox"/> Psychosis / Delirium			<input type="checkbox"/> Lumbar spondylolysis
<input type="checkbox"/> Skull fracture			<input type="checkbox"/> Spondylolisthesis
<input type="checkbox"/> Post concussion syndrome			<input type="checkbox"/> Congenital anomalies
<input type="checkbox"/> Anoxic brain damage			<input type="checkbox"/> Malignant neoplasm Specify: _____
<input type="checkbox"/> Hydrocephalus			<input type="checkbox"/> Benign neoplasm Specify: _____
<input type="checkbox"/> Intracranial Abscess / Meningitis			
<input type="checkbox"/> Malignant neoplasm of brain Specify: _____			
<input type="checkbox"/> Benign neoplasm of brain Specify: _____			
<input type="checkbox"/> Subarachnoid hemorrhage			
<input type="checkbox"/> Cerebral laceration and contusion			
<input type="checkbox"/> Subarachnoid, subdural or extra- dural hemorrhage following injury			
<input type="checkbox"/> Congenital anomalies			

TEMPORAL BONE CT	NECK CT/CTA
<input type="checkbox"/> Vertigo <input type="checkbox"/> Peripheral or <input type="checkbox"/> Central	<input type="checkbox"/> Enlargement of lymph nodes
<input type="checkbox"/> Labyrinthitis	<input type="checkbox"/> Acute pharyngitis
<input type="checkbox"/> Tinnitus	<input type="checkbox"/> Cellulitis or abscess of neck or oral soft tissue
<input type="checkbox"/> Acute mastoiditis	<input type="checkbox"/> Malignant neoplasm of neck Specify: _____
<input type="checkbox"/> Otitis media	<input type="checkbox"/> Benign neoplasm of neck Specify: _____
<input type="checkbox"/> Otitis externa	<input type="checkbox"/> Paralysis of vocal cords or larynx
<input type="checkbox"/> Cholesteatoma	<input type="checkbox"/> Fracture of larynx or trachea
<input type="checkbox"/> Complication following mastoidectomy	<input type="checkbox"/> Congenital anomalies Specify: _____
<input type="checkbox"/> Anomalies of ear causing impairment of hearing Specify: _____	<input type="checkbox"/> Neck injury

DENTAL CT
<input type="checkbox"/> Dentascan, Mandible
<input type="checkbox"/> Dentascan, Maxilla
<input type="checkbox"/> Maxilla CT view, SIM/Plant
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