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Standard Register © ZIPSET®

**STRONG HEALTH**

HIGHLAND HOSPITAL

**RADIOLOGIC CONSULTATION  
HH 523H MR**

**CT EXAMINATION  
ABDOMEN, PELVIS,  
CHEST, EXTREMITY**

- Inpatient
- Outpatient
- ED
- ICU

NAME

MEDICAL RECORD #:

BIRTHDATE

PCP:

<b>AREA TO BE EXAMINED / TYPE OF EXAMINATION</b>		SCHEDULED DATE:	<b>FOR EMERGENCY CONSULTATIONS</b> AFTER 4 PM MON. - FRI., SATURDAY, SUNDAY AND HOLIDAYS, FAX TO STRONG MEMORIAL RADIOLOGY (585) 506-0062	
		FLOOR		
<b>DIAGNOSIS OR CLINICAL SUSPICION (REQUIRED)</b> <i>Rule out diagnosis not acceptable</i>		SEND PHYSICIAN'S PERSONAL COPY TO:		
		NAME:		MD
		FIRST                      LAST		
		ADDRESS		
<b>HISTORY / CLINICAL INFORMATION (REQUIRED)</b>		STREET		CITY                      ZIP
		<b>CLINICIAN SIGNATURE</b>		
		ATTENDING/RESIDENT/NP/PA		
		BEEPER		
		RESIDENT		
<b>PATIENT POTENTIALLY PREGNANT?</b> <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, LMP		FOR URGENT / EMERGENCY RESULTS MON. - FRI. AFTER 5 PM & WEEKENDS, PLEASE INCLUDE FAX #.		
<b>BUN</b>	<b>Creatinine</b>	<b>PRECAUTIONS</b>		
<b>CHECK ALL THAT APPLY (REQUIRED) Diagnosis or Clinical Suspicion - Symptoms</b>		FAX #:		
<b>ABDOMINAL CT</b>	<b>ABDOMINAL CT (continued)</b>	<b>PELVIC CT</b>	<b>CHEST CT</b>	
<input type="checkbox"/> Abdominal pain <input type="checkbox"/> Abdominal tenderness / rigidity <input type="checkbox"/> Renal colic <input type="checkbox"/> Nausea and/or vomiting <input type="checkbox"/> Abnormal bowel sounds <input type="checkbox"/> Diarrhea <input type="checkbox"/> Jaundice <input type="checkbox"/> Abdominal mass / swelling <input type="checkbox"/> Ascites <input type="checkbox"/> Injury to abdomen <input type="checkbox"/> Injury to pelvis <input type="checkbox"/> Paralytic ileus <input type="checkbox"/> Intestinal obstruction <input type="checkbox"/> Peptic ulcer <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Liver disease <input type="checkbox"/> Cholecystitis <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Peritonitis <input type="checkbox"/> Complications of transplanted organ, liver <input type="checkbox"/> Postoperative infection <input type="checkbox"/> Hemorrhage / seroma complicating procedure <input type="checkbox"/> Abscess intestinal <input type="checkbox"/> Appendicitis <input type="checkbox"/> Ulcerative colitis <input type="checkbox"/> Bowel obstruction <input type="checkbox"/> Renal calculus <input type="checkbox"/> Abdominal aortic aneurysm <input type="checkbox"/> Aortic dissection <input type="checkbox"/> Multiple myeloma	<input type="checkbox"/> Benign tumor Specify: _____ <input type="checkbox"/> Malignant tumor Specify: _____ <input type="checkbox"/> Lymphoma  <b>EXTREMITY CT</b> <input type="checkbox"/> Injury/fracture <input type="checkbox"/> Foreign body <input type="checkbox"/> Penetrating injury Site: _____ <input type="checkbox"/> Arthropathy <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Loose body <input type="checkbox"/> Osteochondritis dissecans <input type="checkbox"/> Cellulitis / abscess <input type="checkbox"/> Infective arthritis <input type="checkbox"/> Muscular calcification <input type="checkbox"/> Chondromalacia <input type="checkbox"/> Joint snapping <input type="checkbox"/> Joint crepitus <input type="checkbox"/> Hypercalcemia <input type="checkbox"/> Abnormal finding on x-ray exam <input type="checkbox"/> Benign tumor Specify: _____ <input type="checkbox"/> Malignant tumor Specify: _____	<input type="checkbox"/> Abdominal pain / cramps <input type="checkbox"/> Abdominal tenderness / rigidity <input type="checkbox"/> Pelvic pain - female organ <input type="checkbox"/> Abdominal mass / swelling <input type="checkbox"/> Pelvic mass / swelling <input type="checkbox"/> Ascites <input type="checkbox"/> Hematuria <input type="checkbox"/> Bowel obstruction <input type="checkbox"/> Injury to abdomen <input type="checkbox"/> Injury to pelvis <input type="checkbox"/> Fracture pelvis <input type="checkbox"/> Cystitis <input type="checkbox"/> Prostatitis <input type="checkbox"/> Calculus ureter / bladder <input type="checkbox"/> Bladder disorder <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Pelvic inflammatory disease <input type="checkbox"/> Fever post-partum <input type="checkbox"/> Menopausal disorders <input type="checkbox"/> Post menopausal disorders <input type="checkbox"/> Uterine leiomyoma <input type="checkbox"/> Abdominal aortic aneurysm / dissection <input type="checkbox"/> Benign tumor Specify: _____ <input type="checkbox"/> Malignant tumor Specify: _____ <input type="checkbox"/> Lymphoma	<input type="checkbox"/> Cough <input type="checkbox"/> Dyspnea <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Fever <input type="checkbox"/> Swelling / lump / mass <input type="checkbox"/> Enlarged lymph nodes <input type="checkbox"/> Abscess of lung <input type="checkbox"/> Pneumonia <input type="checkbox"/> Pneumothorax <input type="checkbox"/> Aspiration pneumonitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Atelectasis <input type="checkbox"/> Pulmonary fibrosis <input type="checkbox"/> Empyema <input type="checkbox"/> Pleurisy <input type="checkbox"/> Esophagitis <input type="checkbox"/> Hernia <input type="checkbox"/> Pulmonary embolism <input type="checkbox"/> Coronary atherosclerosis <input type="checkbox"/> Trauma to chest <input type="checkbox"/> Fractured ribs <input type="checkbox"/> Rib/ chest wall disease <input type="checkbox"/> Disruption of operation wound <input type="checkbox"/> Aortic aneurysm <input type="checkbox"/> Aortic dissection <input type="checkbox"/> Esophageal carcinoma <input type="checkbox"/> Lung carcinoma <input type="checkbox"/> Mesothelioma <input type="checkbox"/> Malignant tumor Specify: _____ <input type="checkbox"/> Lymphoma	

(rev. 9/03)

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