

**RADIOLOGIC CONSULTATION  
517**

**GENERAL  
EXAMINATION**

INPATIENT  NAME  
 OPD  ADDRESS  
 ED  UNIT NO.:  
 PVT  BIRTHDATE  
 COMPENSATION

USE  
ADDRESSOGRAPH  
TYPE  
OR  
PRINT

AREA TO BE EXAMINED / TYPE OF EXAMINATION  <i>ICD9 code:</i> _____	TODAY'S DATE:	SEND PHYSICIAN'S PERSONAL COPY TO:	
	FLOOR/CLINIC	NAME	M.D.
SPECIFIC INFORMATION DESIRED OR QUESTION TO BE ANSWERED	WHEELCHAIR <input type="checkbox"/> CART <input type="checkbox"/>	FIRST	LAST
	PROVISIONAL DIAGNOSIS	ADDRESS	
CLINICAL INFORMATION REQUIRED	STREET	CITY	ZIP
	PATIENT POTENTIALLY PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO	SCHEDULED FOR	
IF YES, LMP		DATE	HOUR <input type="checkbox"/> AM <input type="checkbox"/> PM
BUN mg%   BILIRUBIN mg%   RBC	ROOM	TECHNOLOGIST	C _____ F _____
CAUTIONS/RISKS	QUALITY CONTROL		D _____ H _____
	ADDITIONAL INFORMATION		E _____
PRINT PHYSICIAN'S NAME		ARRIVED _____	
ATTENDING		COMPLETED _____	
HOUSE STAFF			

**The following exams may be requested with this form:**

**HEAD AND NECK**

EYE  
 MANDIBLE  
 MASTOIDS  
 FACIAL  
 NASAL  
 SINUS  
 OPTIC FORAMINA  
 SELLA TURCICA  
 SKULLS  
 TM JOINTS  
 SALIVARY GLANDS  
 NECK SOFT TISSUE

**SPINES**

CERVICAL  
 THORACIC  
 LUMBOSACRAL  
 SACRUM, COCCYX  
 PELVIS, SI JOINTS  
 SPINE MARKER  
 SCOLIOSIS SERIES

**ABDOMEN**

ABDOMEN KUB  
 ABD. MULTI VIEWS  
 PELVIMETRY

**UPPER EXTREMITY**

CLAVICLE  
 SHOULDER  
 HUMERUS  
 ELBOW  
 FOREARM  
 WRIST  
 HAND  
 FINGER

**LOWER EXTREMITY**

HIP  
 HIP in OR  
 FEMUR  
 KNEE  
 TIBIA FIBULA  
 ANKLE  
 FOOT  
 TOE  
 HEEL

**OTHER BONE - JOINTS**

JOINT SURVEY  
 METASTATIC SURVEY  
 BONE DENSITOMETRY  
 BONE LENGTH  
 LONG BONE PEDIATRIC  
 BONE AGE

**BREAST**

(Scheduling Required 585-275-5434)  
 MAMMOGRAM  
 BREAST SPECIMEN  
 MAMMARY DUCT INJECTION  
 BREAST BIOPSY LOC.

**MISCELLANEOUS**

FLUOROSCOPY  
 PORTABLE  
 TOMOGRAPHY  
 OPERATING ROOM  
 MAGNIFICATION

Report or Film Requests.  
 (585) 275-5368

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