

INPATIENT

OPD

ED

PVT

COMPENSATION

NAME:

ADDRESS:

UNIT NUMBER#:

BIRTHDATE:

AREA TO BE EXAMINED / TYPE OF EXAMINATION (check all that apply) ICD9 code: _____	TODAY'S DATE:	SEND PHYSICIAN'S PERSONAL COPY TO:	
	FLOOR/CLINIC	NAME:	M.D.
DIAGNOSIS OR CLINICAL SUSPICION (REQUIRED) Rule out diagnosis not acceptable	WHEELCHAIR <input type="checkbox"/>	FIRST	LAST
	CART <input type="checkbox"/>	ADDRESS	
HISTORY / CLINICAL INFORMATION (REQUIRED)	STREET CITY ZIP		
	PHYSICIAN'S SIGNATURE		
	ATTENDING		BEEPER
	RESIDENT		
PATIENT POTENTIALLY PREGNANT? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, LMP		SCHEDULED FOR <input type="checkbox"/> AM <input type="checkbox"/> PM	
BUN mg%	BILIRUBIN mg%	RBC	DATE HOUR
CAUTIONS/RISKS		ROOM	TECHNOLOGIST
		C _____ F _____	
		D _____ H _____	
		E _____	
		ADDITIONAL INFORMATION	
		ARRIVED _____	
		COMPLETED _____	

SEE REVERSE SIDE FOR EXAMS THAT MAY BE REQUESTED WITH THIS FORM. ALL EXAMS MUST BE SCHEDULED.

ENSURE PROPER PREPARATION FOR FOLLOWING EXAMS

GASTRO INTESTINAL
GENITO UROLOGIC

ANGIOGRAPHIC
NEUROLOGIC (MYELOGRAMS)

NOTE: PREP INSTRUCTIONS AVAILABLE ON PATIENT UNITS, CLINICS OR BY CALLING 585-275-5434

PLEASE COMPLETE FOR MAGNETIC RESONANCE EXAMINATION CONTRAINDICATIONS OR RISKS

CARDIAC PACEMAKER	<input type="checkbox"/> YES	<input type="checkbox"/> NO
INTRACRANIAL ANEURYSM CLIPS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
CORONARY ARTERY BYPASS GRAFT	<input type="checkbox"/> YES	<input type="checkbox"/> NO
OTHER VASCULAR CLIPS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
METAL FRAGMENTS IN THE EYE	<input type="checkbox"/> YES	<input type="checkbox"/> NO

X-Ray Special Examination 519

The following exams may be requested with this form:

GASTRO INTESTINAL

ESOPHAGRAM
UPPER GI
UPPER GI & SMALL BOWEL
SMALL BOWEL, ANTEGRADE
BARIUM ENEMA
BARIUM ENEMA, AIR CONTRAST
HYPOTONIC DUODENOGRAM
ERCP
COLONOSCOPY
FISTULA OR SINUS TRACT
CHOLECYSTOGRAPHY, ORAL
CHOLANGIOGRAPHY, IV (INC. TOMO)
CHOLANGIOGRAPHY, POST OP
CHOLANGIOGRAPHY, TRANSHEPATIC
ESOPHAGEAL DILATATION
BILIARY DRAINAGE
BILIARY STONE REMOVAL
ENTEROCLYSIS

ANGIOGRAPHIC

LYMPHOGRAM
ANGIOCARDIOGRAPHY
CORONARY ROOT ARTERIOGRAPHY
CORONARY ARTERIOGRAPHY
PULMONARY ANGIOGRAPHY
CAVAGRAM
PHLEBOGRAM/VENOGRAPHY, UNILAT.
PHLEBOGRAM/VENOGRAPHY, BILAT.
ABDOMINAL AORTOGRAPHY
AORTOGRAPHY INC. LOWER EXTREM.
THORACIC AORTOGRAPHY
VISCERAL ARTERIOGRAPHY
ARTERIOGRAPHY IN O.R.
RENAL-AORTOGRAPHY
BRACHIOCEPHALIC
CAROTID/VERT. ANGIO. 1 VESSEL
CAROTID/VERT. ANGIO. 2+ VESSELS
ARTERIAL DILATATION
CORONARY DILATATION
CORONARY ANGIOPLASTY
PERIPHERAL ARTERIOGRAPHY

GENITO UROLOGIC

EXCRETORY UROGRAPHY (NO TOMO)
EXCRETORY UROGRAPHY (WITH TOMO)
RETROGRADE UROGRAPHY
VOIDING CYSTOURETHROGRAPHY
CYSTOGRAPHY
RETROGRADE URETHROGRAPHY
PERC. NEPHROSTOMY
PERC. NEP. TUBE EXCHANGE
NEPH. TUBE RE-INJECT
RENAL CYST (MASS) PUNCTURE
HYSTEROSALPINGOGRAPHY

C.T. SCANS

C.T. HEAD (NO CONTRAST)
C.T. HEAD (WITH CONTRAST)
C.T. HEAD (PRE + POST CONTRAST)
C.T. CHEST (NO CONTRAST)
C.T. CHEST (WITH CONTRAST)
C.T. CHEST (PRE + POST CONTRAST)
C.T. ABDOMEN (NO CONTRAST)
C.T. ABDOMEN (WITH CONTRAST)
C.T. ABDOMEN (PRE + POST CONTRAST)
C.T. SPINE (NO CONTRAST)
C.T. SPINE (WITH CONTRAST)
C.T. SPINE (PRE + POST CONTRAST)
C.T. ABBREVIATED STUDY (3 SCANS OR LESS)
C.T. RECONSTRUCTION
C.T. EXTREMITY
C.T. BIOPSIES

ARTHROGRAPHIC

ARTHROGRAPHY, KNEE
ARTHROGRAPHY, TM JOINT
ARTHROGRAPHY, OTHER JOINT

NEUROLOGIC

LUMBAR MYELOGRAPHY
CERVICAL/THORACIC MYELOGRAPHY
COMPLETE MYELOGRAPHY
MYELOGRAPHY, PART. (WATER SOL.)
MYELOGRAPHY, COMP. (WATER SOL.)

BIOPSIES

LUNG
KIDNEY
LIVER
PLEURA
RENAL LOCALIZATION FOR BIOPSY
RETRO, PYELO, WITH BRUSH BIOPSY

M.R.I. SCANS

MRI HEAD
MRI NECK
MRI CHEST
MRI HEART
MRI ABDOMEN
MRI PELVIS
MRI CERVICAL SPINE
MRI THORACIC SPINE
MRI LUMBAR SPINE
MRI T.M. JOINT
MRI EXTREMITY
MRI SPECTROSCOPY

MISCELLANEOUS

FLUOROSCOPY

Please ensure that patient is properly prepared

All Special Examinations must be scheduled:

GI and GU Exams (585) 275-5268, FAX: (585) 256-2456
Angiographic Exams (585) 273-4080, FAX: (585) 473-5734
C.T. Exams. (585) 275-5188, FAX: (585) 275-1136
Arthrographic, Myelograms, Biopsies (585) 275-5268, FAX: (585) 256-2456
MRI Exams. (585) 275-5351, FAX: (585) 273-1060
Reports or Film Requests (585) 275-5368, FAX: (585) 273-1062

Mailing Address: Diagnostic Radiology
Strong Memorial Hospital
Department of Radiology, Box 648
Rochester, NY 14642-8648

Mailing Address: MR Center
Strong Memorial Hospital
MR Center, Box 694
Rochester, NY 14642-8694