

SPECIAL EXAMINATION

INPATIENT NAME:
 OPD ADDRESS:
 ED UNIT NUMBER#:
 PVT BIRTHDATE:
 COMPENSATION

AREA TO BE EXAMINED / TYPE OF EXAMINATION (check all that apply) <input type="checkbox"/> Cervical Myelogram ICD 9-code: _____ <input type="checkbox"/> Thoracic Myelogram ICD 9-code: _____ <input type="checkbox"/> Lumbar Myelogram ICD 9-code: _____ <input type="checkbox"/> Cervical Puncture <input type="checkbox"/> Lumbar Puncture <input type="checkbox"/> Per Procedure Provider: _____		TODAY'S DATE: _____ FLOOR/CLINIC _____ WHEELCHAIR <input type="checkbox"/> CART <input type="checkbox"/>	SEND PHYSICIAN'S PERSONAL COPY TO: NAME: _____ M.D. FIRST LAST ADDRESS STREET CITY ZIP PHYSICIAN'S SIGNATURE ATTENDING _____ RESIDENT _____ BEEPER _____ SCHEDULED FOR _____ <input type="checkbox"/> AM _____ <input type="checkbox"/> PM DATE HOUR
DIAGNOSIS OR CLINICAL SUSPICION (REQUIRED) Rule out diagnosis not acceptable		HISTORY / CLINICAL INFORMATION (REQUIRED)	
• Is this Workman's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No Authorization # _____ • Patient's Insurance Provider: <input type="checkbox"/> Preferred Care <input type="checkbox"/> Excellus <input type="checkbox"/> Other _____ • Insurance Pre-Authorization # _____ • Does the patient have a MRI of the spine? <input type="checkbox"/> Yes <input type="checkbox"/> No Where are the images? _____ • Patient on Coumadin? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, hold 4-5 days prior to exam per PCP) • Patient allergic to radiographic contrast? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, premedication is required)		ROOM _____ TECHNOLOGIST C _____ F _____ D _____ H _____ E _____ ADDITIONAL INFORMATION ARRIVED _____ COMPLETED _____	
PATIENT POTENTIALLY PREGNANT? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, LMP _____		BUN mg% BILIRUBIN mg% RBC	
CAUTIONS/RISKS			

**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 ANGIOGRAPHIC
 GENITO UROLOGIC 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 DUODENOGAM
 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 Imaging Sciences, Box 648
 Rochester, NY 14642-8648

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