

SPECIAL EXAMINATION

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

AREA TO BE EXAMINED / TYPE OF EXAMINATION Biopsy of: <input type="checkbox"/> Skull <input type="checkbox"/> Skull base <input type="checkbox"/> Orbits <input type="checkbox"/> Face <input type="checkbox"/> Neck <input type="checkbox"/> Vertebral body (specify vertebral body) _____ <input type="checkbox"/> Paraspinal (specify level) _____ <input type="checkbox"/> Sacrum (specify level) _____ <input type="checkbox"/> Disc Biopsy or Aspiration (specify level) _____		TODAY'S DATE: FLOOR/CLINIC WHEELCHAIR <input type="checkbox"/> CART <input type="checkbox"/> ICD9 code:	SEND PHYSICIAN'S PERSONAL COPY TO: NAME: _____ M.D. FIRST LAST ADDRESS STREET CITY ZIP PHYSICIAN'S SIGNATURE ATTENDING _____ BEEPER _____ RESIDENT _____
DIAGNOSIS OR CLINICAL SUSPICION (REQUIRED) Rule out diagnosis not acceptable Diagnosis: _____ _____ Symptoms: _____		SCHEDULED FOR _____ AM _____ PM DATE HOUR ROOM TECHNOLOGIST C _____ F _____ D _____ H _____ E _____	
HISTORY / CLINICAL INFORMATION (REQUIRED) • Patient on Coumadin? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, hold 4-5 days prior to exam per PCP) • Please send specimen for: <input type="checkbox"/> Cytopathology <input type="checkbox"/> Microbiology <input type="checkbox"/> Flow Cytometry <input type="checkbox"/> Gramstain, Culture Sensitivity, AFB, Fungi, Anaerobe <input type="checkbox"/> Lymphoma Protocol		ADDITIONAL INFORMATION ARRIVED _____ COMPLETED _____	
Platelet Count: _____ INR: _____ PT: _____ PTT: _____		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 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