

**CT EXAMINATION HEAD,
NECK and SPINE**

- INPATIENT
- OPD
- ED

NAME:

MEDICAL RECORD #:

BIRTHDATE:

PCP:

<p>AREA TO BE EXAMINED / TYPE OF EXAMINATION: (check all that apply)</p> <p>CT Guided Biopsy of Cervical Spine</p> <p>Please biopsy: <input type="checkbox"/> C1 <input type="checkbox"/> C2 <input type="checkbox"/> C3 <input type="checkbox"/> C4 <input type="checkbox"/> C5 <input type="checkbox"/> C6 <input type="checkbox"/> C7</p>	<p>SCHEDULED DATE:</p> <hr/> <p>FLOOR/CLINIC</p> <hr/> <p>WHEELCHAIR <input type="checkbox"/></p> <p>CART <input type="checkbox"/></p> <p>ICD-9 CODES</p> <hr/>	<p>SEND PHYSICIAN'S PERSONAL COPY TO:</p> <p>NAME: _____ M.D.</p> <p style="text-align: center;">FIRST LAST</p> <hr/> <p>ADDRESS</p> <hr/> <p>STREET CITY ZIP</p> <hr/> <p>PHYSICIAN'S SIGNATURE</p> <p>ATTENDING _____ BEEPER</p> <p>RESIDENT _____</p>
<p>DIAGNOSIS OR CLINICAL SUSPICION (REQUIRED)</p> <p>Rule out diagnosis not acceptable</p> <p>Diagnosis: _____</p> <hr/> <p>Symptoms: _____</p> <hr/> <p>Platelet Count: _____ INR: _____ PT: _____ PTT: _____</p>	<p>HISTORY / CLINICAL INFORMATION (REQUIRED)</p> <hr/> <p>PATIENT POTENTIALLY PREGNANT? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, LMP</p>	
<p>BUN _____ Creatinine _____</p> <p>CAUTIONS/RISKS</p> <hr/>	<p>RADIOLOGY PROTOCOL:</p> <p style="text-align: right;">Initials _____</p> <hr/> <p>RADIOLOGY PRELIMINARY REPORT:</p> <p style="text-align: right;">Initials _____</p>	

CHECK ALL THAT APPLY (REQUIRED): Diagnosis or Clinical Suspicion - Symptoms

<p>HEAD CT / CTA</p> <ul style="list-style-type: none"> <input type="checkbox"/> Headache <input type="checkbox"/> Convulsions <input type="checkbox"/> Syncope and collapse <input type="checkbox"/> Cognitive deficits - altered level of consciousness <input type="checkbox"/> Aphasia <input type="checkbox"/> Other speech and language deficits <input type="checkbox"/> Hemiplegia / Hemiparesis <ul style="list-style-type: none"> <input type="checkbox"/> Dominant <input type="checkbox"/> Nondominant <input type="checkbox"/> Monoplegia, upper limb <ul style="list-style-type: none"> <input type="checkbox"/> Dominant <input type="checkbox"/> Nondominant <input type="checkbox"/> Monoplegia, lower limb <ul style="list-style-type: none"> <input type="checkbox"/> Dominant <input type="checkbox"/> Nondominant <input type="checkbox"/> Other paralytic syndrome <input type="checkbox"/> TIA <input type="checkbox"/> Impending CVA <input type="checkbox"/> Dementia <input type="checkbox"/> Psychosis / Delirium <input type="checkbox"/> Skull fracture <input type="checkbox"/> Post concussion syndrome <input type="checkbox"/> Anoxic brain damage <input type="checkbox"/> Hydrocephalus <input type="checkbox"/> Intracranial Abscess / Meningitis <input type="checkbox"/> Malignant neoplasm of brain <ul style="list-style-type: none"> Specify: _____ <input type="checkbox"/> Benign neoplasm of brain <ul style="list-style-type: none"> Specify: _____ <input type="checkbox"/> Subarachnoid hemorrhage <input type="checkbox"/> Cerebral laceration and contusion <input type="checkbox"/> Subarachnoid, subdural or extradural hemorrhage following injury <input type="checkbox"/> Congenital anomalies 	<p>FACE CT</p> <ul style="list-style-type: none"> <input type="checkbox"/> Injury of face and neck <input type="checkbox"/> Malignant neoplasm of face <ul style="list-style-type: none"> Specify: _____ <input type="checkbox"/> Benign neoplasm of face <ul style="list-style-type: none"> Specify: _____ <input type="checkbox"/> Acute sinusitis <input type="checkbox"/> Chronic sinusitis <input type="checkbox"/> Nasal polyps <input type="checkbox"/> Disturbance of salivary secretion <input type="checkbox"/> Jaw lesion <input type="checkbox"/> Temporomandibular joint disorder <input type="checkbox"/> Fracture <ul style="list-style-type: none"> Specify: _____ <p>TEMPORAL BONE CT</p> <ul style="list-style-type: none"> <input type="checkbox"/> Vertigo <input type="checkbox"/> Peripheral or <input type="checkbox"/> Central <input type="checkbox"/> Labyrinthitis <input type="checkbox"/> Tinnitus <input type="checkbox"/> Acute mastoiditis <input type="checkbox"/> Otitis media <input type="checkbox"/> Otitis externa <input type="checkbox"/> Cholesteatoma <input type="checkbox"/> Complication following mastoidectomy <input type="checkbox"/> Anomalies of ear causing impairment of hearing <ul style="list-style-type: none"> Specify: _____ 	<p>ORBIT CT</p> <ul style="list-style-type: none"> <input type="checkbox"/> Acute inflammation of orbit <input type="checkbox"/> Orbital edema or congestion <input type="checkbox"/> Ophthalmoplegia <input type="checkbox"/> Malignant neoplasm of orbit <ul style="list-style-type: none"> Specify: _____ <input type="checkbox"/> Benign neoplasm of orbit <ul style="list-style-type: none"> Specify: _____ <input type="checkbox"/> Congenital anomalies <input type="checkbox"/> Retinal disease <input type="checkbox"/> Choroidal disease <p>NECK CT / CTA</p> <ul style="list-style-type: none"> <input type="checkbox"/> Enlargement of lymph nodes <input type="checkbox"/> Acute pharyngitis <input type="checkbox"/> Cellulitis or abscess of neck or oral soft tissue <input type="checkbox"/> Malignant neoplasm of neck <ul style="list-style-type: none"> Specify: _____ <input type="checkbox"/> Benign neoplasm of neck <ul style="list-style-type: none"> Specify: _____ <input type="checkbox"/> Paralysis of vocal cords or larynx <input type="checkbox"/> Fracture of larynx or trachea <input type="checkbox"/> Congenital anomalies <ul style="list-style-type: none"> Specify: _____ <input type="checkbox"/> Neck injury 	<p>CERVICAL, THORACIC LUMBAR SPINE CT</p> <ul style="list-style-type: none"> <input type="checkbox"/> Spinal cord injury <input type="checkbox"/> Fracture of vertebral column <ul style="list-style-type: none"> Specify: _____ <input type="checkbox"/> Compression of spinal nerve root <input type="checkbox"/> Sciatica <input type="checkbox"/> Spondylosis without myelopathy <input type="checkbox"/> Spondylosis with myelopathy <input type="checkbox"/> Disc displacement <input type="checkbox"/> Disc degeneration <input type="checkbox"/> Spinal stenosis <input type="checkbox"/> Post Laminectomy syndrome <input type="checkbox"/> Discitis <input type="checkbox"/> Osteomyelitis <input type="checkbox"/> Lumbar spondylolysis <input type="checkbox"/> Spondylolisthesis <input type="checkbox"/> Congenital anomalies <input type="checkbox"/> Malignant neoplasm <ul style="list-style-type: none"> Specify: _____ <input type="checkbox"/> Benign neoplasm <ul style="list-style-type: none"> Specify: _____ <p>DENTAL CT</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dentscan, Mandible <input type="checkbox"/> Dentscan, Maxilla <input type="checkbox"/> Maxilla CT view, SIM/Plant <input type="checkbox"/> Mandible CT view, SIM/Plant
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Report or Film Requests: (585) 275-5368
CT Exam Scheduling: (585) 275-5188

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

ROOM	TECHNOLOGIST	QUALITY CONTROL	# OF FILMS

EXAM #1

EXAM #2