STRONG HEALTH

Strong Memorial Hospital

RADIOLOGIC CONSULTATION 517

GENERAL EXAMINATION

INPATIENT ☐
OPD ☐
ED ☐
PVT ☐
COMPENSATION ☐

NAME
ADDRESS
UNIT NO.:
BIRTHDATE

USE ADDRESSOGRAPH TYPE OR PRINT

AREA TO BE EXAMINED / TYPE OF EXAMINATION

ICD9 code: ____________________

TODAY'S DATE:

FLOOR/CLINIC

WHEELCHAIR ☐
CART ☐

SPECIFIC INFORMATION DESIRED OR QUESTION TO BE ANSWERED

PROVISIONAL DIAGNOSIS

CLINICAL INFORMATION REQUIRED

PATIENT POTENTIALLY PREGNANT? ☐ YES ☐ NO | IF YES, LMP

BUN mg% | BILIRUBIN mg% | RBC

CAUTIONS/RISKS

SEND PHYSICIAN'S PERSONAL COPY TO:
NAME FIRST LAST M.D.
ADDRESS
STREET CITY ZIP

SCHEDULED FOR
DATE HOUR ☐ AM ☐ PM

ROOM | TECHNOLOGIST

C ________ F ________
D ________ H ________
E ________ ________

QUALITY CONTROL

ADDITIONAL INFORMATION

ARRIVED

COMPLETED

PRINT PHYSICIAN'S NAME
ATTENDING 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

Mailing Address:
Strong Memorial Hospital
Department of Radiology, Box 648
Rochester, NY 14642
(585) 275-5434

HOSPITAL TUBE STATION 31