

SPECIAL EXAMINATION

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

AREA TO BE EXAMINED / TYPE OF EXAMINATION (check all that apply) Lumbar Puncture <input type="checkbox"/> Intrathecal Chemotherapy <u>ICD9 code:</u> _____ <input type="checkbox"/> CSF Collection <u>ICD9 code:</u> _____		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 _____ DATE HOUR <input type="checkbox"/> AM <input type="checkbox"/> PM
DIAGNOSIS OR CLINICAL SUSPICION (REQUIRED) Rule out diagnosis not acceptable Diagnosis: _____ Symptoms: _____ Platelet Count: _____		HISTORY / CLINICAL INFORMATION (REQUIRED)	
Intrathecal Chemotherapy <input type="checkbox"/> Cytarabine (ARAC) _____ <input type="checkbox"/> Cytarabine Liposome _____ <input type="checkbox"/> Methotrexate _____ <input type="checkbox"/> Hydrocortisone _____ <input type="checkbox"/> Thiotepa _____	Dose _____	CSF Collections <input type="checkbox"/> Tube 1 _____ cc <input type="checkbox"/> Tube 2 _____ cc <input type="checkbox"/> Tube 3 _____ cc <input type="checkbox"/> Tube 4 _____ cc <input type="checkbox"/> Other _____ cc Opening pressure needed <input type="checkbox"/> Yes <input type="checkbox"/> No Comments: _____	Tests Requested _____ ROOM _____ TECHNOLOGIST _____ C _____ F _____ D _____ H _____ E _____ QUALITY CONTROL 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
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