STRONG HEALTH

STRONG MEMORIAL HOSPITAL

# Radiologic Consultation 519

## SPECIAL EXAMINATION

INPATIENT ☐
OPD ☐
ED ☐
PVT ☐
COMPENSATION ☐

NAME:

ADDRESS:

UNIT NUMBER#:

BIRTHDATE:

AREA TO BE EXAMINED / TYPE OF EXAMINATION
(check all that apply)

☐ **Cervical Myelogram** ***ICD 9-code:*** ____________
☐ **Thoracic Myelogram** ***ICD 9-code:*** ____________
☐ **Lumbar Myelogram** ***ICD 9-code:*** ____________

☐ **Cervical Puncture**
☐ **Lumbar Puncture**
☐ **Per Procedure Provider:** ____________

TODAY'S DATE:

FLOOR/CLINIC

WHEELCHAIR ☐
CART ☐

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

SCHEDULED FOR ☐ AM ☐ PM
DATE HOUR

HISTORY / CLINICAL INFORMATION (REQUIRED)

- Is this Workman's Compensation? ☐ Yes ☐ No **Authorization #** ____________
- Is this Preferred Care? ☐ Yes ☐ No **Authorization #** ____________
- **Does the patient have a MRI of the spine?** ☐ Yes ☐ No
  **Where are the images?** ____________
- **Patient on Coumadin?** ☐ Yes ☐ No
  (If yes, hold 4-5 days prior to exam per PCP)
- **Patient allergic to radiographic contrast?** ☐ Yes ☐ No
  (If yes, premedication is required)

| ROOM | TECHNOLOGIST | C ______ | F ______ |
|---|---|---|---|
| QUALITY CONTROL | | D ______ | H ______ |
| | | E ______ | ______ |
| ADDITIONAL INFORMATION | | ARRIVED | |
| | | COMPLETED | |

PATIENT POTENTIALLY PREGNANT? ☐ NO ☐ 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 | ☐ YES | ☐ NO |
| INTRACRANIAL ANEURYSM CLIPS | ☐ YES | ☐ NO |
| CORONARY ARTERY BYPASS GRAFT | ☐ YES | ☐ NO |
| OTHER VASCULAR CLIPS | ☐ YES | ☐ NO |
| METAL FRAGMENTS IN THE EYE | ☐ YES | ☐ NO |

**Report or Film Requests.**
**(585) 275-5368**

**HOSPITAL TUBE STATION 31**

**Mailing Address:**
**Strong Memorial Hospital**
**Department of Radiology, Box 648**
**Rochester, NY 14642-8648**
**(585) 275-5434**

PLW/CZink:mk 10/12/05

# 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-INECT
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**