

**CT EXAMINATION HEAD,
NECK and SPINE**

- INPATIENT
- OPD
- ED

NAME:

MEDICAL RECORD #:

BIRTHDATE:

PCP:

AREA TO BE EXAMINED / TYPE OF EXAMINATION:		SCHEDULED DATE:	SEND PHYSICIAN'S PERSONAL COPY TO: NAME: _____ M.D. FIRST LAST	
		FLOOR/CLINIC		
DIAGNOSIS OR CLINICAL SUSPICION (REQUIRED) <i>Rule out diagnosis not acceptable</i>		WHEELCHAIR <input type="checkbox"/>	ADDRESS STREET CITY ZIP	
		CART <input type="checkbox"/>		
		ICD-9 CODES		PHYSICIAN'S SIGNATURE ATTENDING _____ BEEPER RESIDENT _____
HISTORY / CLINICAL INFORMATION (REQUIRED)		RADIOLOGY PROTOCOL: Initials _____		
		RADIOLOGY PRELIMINARY REPORT: Initials _____		
PATIENT POTENTIALLY PREGNANT? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, LMP				
BUN	Creatinine	CAUTIONS/RISKS		

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

<p style="text-align: center; background-color: #008080; color: white; padding: 2px;">HEAD CT / CTA</p> <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 <input type="checkbox"/> Dominant <input type="checkbox"/> Nondominant <input type="checkbox"/> Monoplegia, upper limb <input type="checkbox"/> Dominant <input type="checkbox"/> Nondominant <input type="checkbox"/> Monoplegia, lower limb <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 Specify: _____ <input type="checkbox"/> Benign neoplasm of brain 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 style="text-align: center; background-color: #008080; color: white; padding: 2px;">FACE CT</p> <input type="checkbox"/> Injury of face and neck <input type="checkbox"/> Malignant neoplasm of face Specify: _____ <input type="checkbox"/> Benign neoplasm of face 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 Specify: _____	<p style="text-align: center; background-color: #008080; color: white; padding: 2px;">ORBIT CT</p> <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 Specify: _____ <input type="checkbox"/> Benign neoplasm of orbit Specify: _____ <input type="checkbox"/> Congenital anomalies <input type="checkbox"/> Retinal disease <input type="checkbox"/> Choroidal disease	<p style="text-align: center; background-color: #008080; color: white; padding: 2px;">CERVICAL, THORACIC LUMBAR SPINE CT</p> <input type="checkbox"/> Spinal cord injury <input type="checkbox"/> Fracture of vertebral column 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 Specify: _____ <input type="checkbox"/> Benign neoplasm Specify: _____
<p style="text-align: center; background-color: #008080; color: white; padding: 2px;">TEMPORAL BONE CT</p> <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 Specify: _____	<p style="text-align: center; background-color: #008080; color: white; padding: 2px;">NECK CT / CTA</p> <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 Specify: _____ <input type="checkbox"/> Benign neoplasm of neck Specify: _____ <input type="checkbox"/> Paralysis of vocal cords or larynx <input type="checkbox"/> Fracture of larynx or trachea <input type="checkbox"/> Congenital anomalies Specify: _____ <input type="checkbox"/> Neck injury	<p style="text-align: center; background-color: #008080; color: white; padding: 2px;">DENTAL CT</p> <input type="checkbox"/> Dentascan, Mandible <input type="checkbox"/> Dentascan, Maxilla <input type="checkbox"/> Maxilla CT view, SIM/Plant <input type="checkbox"/> Mandible CT view, SIM/Plant	

Report or Film Requests: (585) 275-5368
CT Exam Scheduling: (585) 275-5188

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