

SPECIAL EXAMINATION

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

AREA TO BE EXAMINED / TYPE OF EXAMINATION (check all that apply) <input type="checkbox"/> Cervical Myelogram ICD 9-code: _____ <input type="checkbox"/> Thoracic Myelogram ICD 9-code: _____ <input type="checkbox"/> Lumbar Myelogram ICD 9-code: _____ <input type="checkbox"/> Cervical Puncture <input type="checkbox"/> Lumbar Puncture <input type="checkbox"/> Per Procedure Provider: _____ Print Images to Film? <input type="checkbox"/> Yes <input type="checkbox"/> No		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 _____ BEEPER _____ RESIDENT _____ SCHEDULED FOR _____ <input type="checkbox"/> AM <input type="checkbox"/> PM DATE HOUR
DIAGNOSIS OR CLINICAL SUSPICION (REQUIRED) Rule out diagnosis not acceptable		ROOM _____ TECHNOLOGIST C _____ F _____ D _____ H _____ E _____ ADDITIONAL INFORMATION ARRIVED _____ COMPLETED _____	
HISTORY / CLINICAL INFORMATION (REQUIRED) • Is this Workman's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No Authorization # _____ • Patient's Insurance Provider: <input type="checkbox"/> Preferred Care <input type="checkbox"/> Excellus <input type="checkbox"/> Other _____ • Insurance Pre-Authorization # _____ • Does the patient have a MRI of the spine? <input type="checkbox"/> Yes <input type="checkbox"/> No Where are the images? _____ • Patient on Coumadin? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, hold 4-5 days prior to exam per PCP) • Patient allergic to radiographic contrast? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, premedication is required)			
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 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	<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 Imaging Sciences, Box 648
Rochester, NY 14642-8648

Mailing Address: MR Center
Strong Memorial Hospital
MR Center, Box 694
Rochester, NY 14642-8694