

INPATIENT

OPD

ED

PVT

COMPENSATION

NAME:

ADDRESS:

UNIT NUMBER#:

BIRTHDATE:

AREA TO BE EXAMINED / TYPE OF EXAMINATION (check all that apply)  ICD9 code: _____	TODAY'S DATE:	SEND PHYSICIAN'S PERSONAL COPY TO:	
	FLOOR/CLINIC	NAME:	M.D.
DIAGNOSIS OR CLINICAL SUSPICION <b>(REQUIRED)</b> Rule out diagnosis not acceptable	WHEELCHAIR <input type="checkbox"/>	FIRST	LAST
	CART <input type="checkbox"/>	ADDRESS	
HISTORY / CLINICAL INFORMATION <b>(REQUIRED)</b>	STREET CITY ZIP		
	<b>PHYSICIAN'S SIGNATURE</b>		
	ATTENDING		BEEPER
	RESIDENT		
PATIENT POTENTIALLY PREGNANT? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, LMP		SCHEDULED FOR <input type="checkbox"/> AM <input type="checkbox"/> PM	
BUN mg%	BILIRUBIN mg%	RBC	DATE HOUR
CAUTIONS/RISKS		ROOM	TECHNOLOGIST
		C _____ F _____	
		D _____ H _____	
		E _____	
		ADDITIONAL INFORMATION	
		ARRIVED _____	
		COMPLETED _____	

**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