

# RADIOLOGY PROCEDURE ORDER FORM

PATIENT INFORMATION	
MRN:	_____
Patient Name:	_____
Patient Phone:	_____
Date of Birth:	_____
Insurance:	_____

APPOINTMENT INFORMATION	
Date:	_____
Time:	_____
Reservation Number:	_____
Requesting Service:	_____
Phone:	_____

CT       X-Ray       Mammography       MRI       Nuclear Medicine       Ultrasound

**\*Ultrasound of the breast may be done in addition to mammography at the discretion of the radiologist.  
 Please call 996-0241 to schedule angiography or interventional radiology procedures.**

Procedure:	_____
Clinical History:	_____ _____ _____
ICD-9 Code:	_____
Additional Information:	_____ _____ _____

IV Contrast?		
Without <input type="checkbox"/>	With <input type="checkbox"/>	Without & With <input type="checkbox"/>
Allergies: _____		
<b>CT: Serum creatinine within 6 months and GFR required for all patients</b>		
Date: _____ SCr: _____ GFR: _____		
<b>MRI: If patient has history of kidney disease or kidney problems, serum creatinine within 6 months and GFR required:</b>		
History of kidney disease/problems? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, Date: _____ SCr: _____ GFR: _____		
<b>Is Pt. Pregnant: Yes <input type="checkbox"/> No <input type="checkbox"/></b>		
<b>Claustrophobic: Yes <input type="checkbox"/> No <input type="checkbox"/></b>		
Other: _____		

Attending Physician (Please Print)	Page #	Ordering Physician's Signature	Page #

**Radiology Scheduling (312)-413-4900**

