

OUTPATIENT IMAGING ORDER FORM

Referral Number (if needed): _____

Last Name: _____ First Name: _____ MI: _____
 Date of Birth: _____ Patient Contact #: _____
 Insured Name: _____ Insured's Date of Birth: _____
 Insurance Name / Policy #: _____
 Diagnosis Code / Reason for Test: _____ Procedure Code: _____
 Test Date: _____ Time: _____ Please arrive _____ minutes prior to test.

(Please include patient demographics, including copies of driver's license and insurance card.)

Circle tests and sites requested. If not listed, please specify under "OTHER".

CT				MRI			
Abdomen	W/O	W/	W & W/O	Abdomen	W/O	W & W/O	
Abdomen/Pelvis	W/O	W/	W & W/O	Brain	W/O	W & W/O	
Chest	W/O	W/	W & W/O	Cardiac	W/O	W & W/O	
Head	W/O	W/	W & W/O	Liver	W/O	W & W/O	
Urogram	W/O	W/	W & W/O	Chest	W/O	W & W/O	
Pelvis	W/O	W/	W & W/O	Pelvis	W/O	W & W/O	
Spine	<i>Cervical</i>	<i>Lumbar</i>	<i>Thoracic</i>	Facial	W/O	W & W/O	
Sinuses	<i>Complete</i>	<i>Limited</i>	<i>Screening</i>	Extremity	R L	W/O	W & W/O
Soft Tissue Neck	W/O	W/	W & W/O	Cervical Spine		W/O	W & W/O
Facial	<i>Specify i.e. orbits</i>			Lumbar Spine		W/O	W & W/O
Extremity	<i>Specify</i> R L			Thoracic Spine		W/O	W & W/O
Other				Pituitary		W/O	W & W/O
				MRA	<i>Renal</i>	<i>Head</i> <i>Neck</i>	<i>Head/Neck</i>

ULTRASOUND

Abdomen				IAC	W/O	W & W/O
Carotid Doppler	<i>Right</i> <i>Left</i> <i>Bilateral</i>	X-RAY				
Doppler Venous		Chest				
Gallbladder		Extremity	<i>Specify</i>	R	L	
Pelvis / Transvaginal		Hip	<i>Right</i>	<i>Left</i>	<i>Bilateral</i>	
OB 1 st Trimester		IVP w/o Tomograms				
OB 2 nd - 3 rd Trimester		KUB				
Renal		Sinuses	<i>Complete</i>	<i>Limited</i>		
Testicular	Skull	<i>Orbits</i>				
Other	Spine	<i>Cervical</i>	<i>Lumbar</i>	<i>Thoracic</i>		

Comments:	UGI
	BA Swallow <i>Specify</i> R L
	Small Bowel
	Barium Enema
	VCUG
	Venogram <i>Specify</i> R L
	Arthrogram <i>Specify</i> R L
	Myelogram <i>Cervical</i> <i>Lumbar</i> <i>Thoracic</i>



5601 Warren Parkway
 Frisco, TX 75034

Physician Signature / Date / Time

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CT Scan	
Procedure	Patient Prep (ONLY IF ORDERED WITH CONTRAST)
Abdomen	} Nothing to eat the day of exam.
Abdomen / Pelvis	
Pelvis	
Soft Tissue Neck	} Clear liquids only for 4 hours prior to exam. (if IV contrast is to be used)
Facial	
Head	
Sinuses	
Upper Extremities	
Chest	

MRI

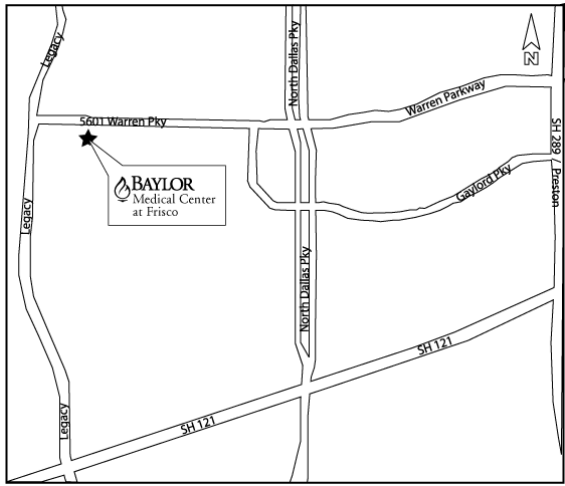
Procedure	Patient Prep	Contraindications
All MRI procedures	Remove all metallic objects before scanning e.g. jewelry, glasses, clothing with metal, non-permanent dentures, credit cards and hairpins. Wear comfortable clothes that have no metal buttons, zippers or snaps, otherwise you will need to change into a gown before the exam. Infusion pumps will be removed before scanning. If being in a small, enclosed place makes you anxious, talk to your physician. An oral sedative may be prescribed to take 1 hour prior to the exam. If an oral sedative is taken, you will need someone to drive you home from your appointment.	In general, an MRI scan cannot be done if you have implanted electronic devices (e.g. cardiac pacemaker). Let the MRI Technologist know if you have any metal implants or prosthetic devices so he/she can determine if MRI is appropriate for you. MRI is generally not recommended for pregnant women during the first trimester.

Ultrasound

Procedure	Patient Prep
Pelvis	} Drink 32 ounces of water 1 hour prior to exam.
Pregnancy	
Transvaginal Pregnancy	
Abdomen	} Nothing to eat or drink after midnight.
Renal	

X-Ray

Procedure	Patient Prep
Myelogram	No pain medications the morning of exam.
Upper GI Small bowel	Nothing to eat after midnight the night prior to exam.
Barium Enema	Nothing to eat after midnight and bowel prep the day before exam.



If you have questions or concerns, please call us:

**Baylor Medical Center at Frisco
Imaging Department**

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