THIS PHYSICIAN ORDER MUST BE PRESENTED AT THE TIME OF SERVICE

Please select if you have a location preference:
- ☐ The Miriam Hospital
- ☐ 195 Collyer St
- ☐ 375 Wampanoag Trail
- ☐ 146 West River Street
- ☐ Rhode Island Hospital
- ☐ Medical Office Center Building (MOC)

Please contact patient to make appointment ☐ Yes ☐ No

☐ STAT ☐ ROUTINE EXPECTED DOS:_______________

First Name: ______________________________ Last Name: ______________________________

DOB:_______________ Phone: _______________ Insurance Plan /Plan #:: ______________________________

ICD 10 Codes (REQUIRED):______________________________

Signs/Symptoms /Reasons for Exam (REQUIRED): ______________________________

Ordering Provider (printed): ______________________________ Office Phone: _______________

**Physician Signature: ****______________________________ Date: _______________

****MUST BE ORIGINAL SIGNATURE ; STAMPED SIGNATURES NOT ACCEPTED**

CT SCAN

CONTRAST
- ☐ IV Contrast ☐ No IV Contrast
- ☐ Oral Contrast ☐ Per Radiologist

CT BRAIN / HEAD
- ☐ Brain ☐ Temporal Bone
- ☐ Mastoid ☐ Brain Venogram
- ☐ Gamma Knife
- ☐ Brain CTA

CT FACE
- ☐ Sinus ☐ Orbits
- ☐ Face

CT NECK
- ☐ Neck ☐ Neck CTA

CT CHEST
- ☐ Chest
- ☐ High Resolution Chest
- ☐ Lung Cancer Screening
- ☐ Pulmonary embolus
- ☐ Aortic Dissection
- ☐ Chest CTA

CT SPINE
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine
- ☐ Post Myelogram ________ spine

SPECIALTY EXAMS
- ☐ CT Virtual Colonoscopy
- ☐ CT Enterography
- ☐ Calcium Scoring
- ☐ Pulmonary Vein Map
- ☐ CTA Coronary

CT ABDOMEN & PELVIS
- ☐ Abdomen & Pelvis
- ☐ Abdomen Pelvis Venogram
- ☐ Renal/Ureter Stone
- ☐ Hematuria
- ☐ CTA Endoleak

CT ABDOMEN
- ☐ Abdomen ONLY (no pelvis)
- ☐ Liver ☐ Adrenal
- ☐ Pancreas ☐ Kidney
- ☐ Renal CTA
- ☐ Abdomen CTA

CT PELVIS
- ☐ Pelvis ONLY (no abdomen)
- ☐ Pelvis CTA

CT EXTREMITIES ☐ RIGHT ☐ LEFT
- ☐ Wrist
- ☐ Elbow
- ☐ Shoulder
- ☐ Hips
- ☐ Femur
- ☐ Knee
- ☐ Tibia/Fibula
- ☐ Ankle
- ☐ Foot /Calcaneous
- ☐ __________ Arthrogram: ______
- ☐ Lower Extremity "Run-Off" CTA
  Levels: __________
- ☐ Upper Extremity CTA
- ☐ Upper Extremity Venogram
- ☐ **Other**______________________

MRI

MRI CONTRAST ☐ With & Without ☐ Without

NEURO
- ☐ Brain: ______________________
  Region of interest: ____________
- ☐ Spectroscopy
- ☐ Functional Brain
- ☐ Soft Tissue Neck: ______________
- ☐ **MR Angiography Head**
  - ☐ Venous Flow
  - ☐ Arterial Flow
- ☐ **MRA Neck:**
  - ☐ Dissection
  - ☐ Atherosclerosis

MR MUSCULO/SKELETAL

SIDE: ☐ RIGHT ☐ LEFT
- ☐ Shoulder ☐ Hip
- ☐ Humerus ☐ Thigh
- ☐ Elbow ☐ Knee
- ☐ Forearm ☐ Lower Leg
- ☐ Wrist ☐ Ankle
- ☐ Hand ☐ Foot
- ☐ _______ Fingers
- ☐ _______ Toes
- ☐ Arthrogram _______________
  ☐ upper ☐ lower

MRI BODY
- ☐ Chest ☐ Adrenals
- ☐ Liver: _________ ☐ Kidneys
- ☐ MRCP/Pancreas
- ☐ Abdomen: _________________
- ☐ Elastography
- ☐ Fetal
- ☐ Pelvis: ____________________
- ☐ MR Enterography ***(Abdomen+Pelvis Study)***

MRA BODY
- ☐ **MRA Chest:** _______________
- ☐ **MRA Abdomen:** _____________
- ☐ **MRA Pelvis:** _______________
- ☐ **MRA Extremity**

Please specify: ______________________

MR SPINE
- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar
- ☐ Entire Spine *(C, T, & L spine)*
- ☐ Brachial Plexus *(MRI Chest study)*
  ☐ RIGHT ☐ LEFT

MRA Spine: __________________

****MRI CARDIAC-Use detailed form***

****MRI BREAST- Use detailed form***

Will patient require anesthesia or pediatric sedation? If yes, please fill out sedation form.

If patient has any of the following conditions, the patient may need a creatinine level drawn within 6 weeks of appointment. Please fax creatinine to 444-5732 if acquired outside Lifespan Laboratories.

- ☐**YES** ☐**NO** **Hypertension or taking medication for high blood pressure**
- ☐**YES** ☐**NO** **Renal Disease or transplant**
- ☐**YES** ☐**NO** **Diabetes**
- ☐**YES** ☐**NO** **Dialysis**

If patient has an implanted electronic device (Pacemaker/ICD/Neurostimulator) please contact the MRI department at 444-4881.

If patient is pregnant and within 1st trimester, please contact the MRI department and speak to an attending radiologist 444-4881.

*To request MRI Cardiac or MRI Breast forms please contact imaging@lifespan.org with your request

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- ☐ Rhode Island Hospital
- ☐ Medical Office Center Building (MOC)
- ☐ Anne Pappas Center

Please contact patient to make appointment ☐ Yes ☐ No

☐ STAT ☐ ROUTINE EXPECTED DOS:________________

First Name: ______________________________ Last Name: ______________________________

DOB:____________________ Phone: ____________________ Insurance Plan /Plan #:: ____________________

ICD 10 Codes (REQUIRED):____

Signs/Symptoms /Reasons for Exam (REQUIRED): ____

Ordering Provider (printed): ______________________________ Office Phone: ____________________

**Physician Signature: ****____ Date: ______________

****MUST BE ORIGINAL SIGNATURE ; STAMPED SIGNATURES NOT ACCEPTED**

U L T R A S O U N D

ULTRASOUND

ABDOMEN
- ☐ Abdomen Complete (with vascular evaluation if needed)
- ☐ Right Upper Quadrant Limited (with vascular evaluation if needed)
- ☐ CCK GB ejection fraction (RIH MOC ONLY)
- ☐ Renal with bladder (Post Void Residual)
- ☐ Renal with blood flow (resistive index) Doppler
- ☐ Renal - no vascular evaluation
- ☐ Renal-Complete Doppler- RAS
- ☐ Renal Transplant with Doppler evaluation
- ☐ Abdominal Aorta Follow up ☐ Abdominal Aorta Screening
- ☐ Liver with Doppler and Elastography

SMALL PARTS
- ☐ Thyroid/Parathyroid
- ☐ Palpable Lump (designated area to be evaluated)________________
- ☐ Thyroid Biopsy **Location**____________________/or ☐**Determined by Radiologist**
- ☐ Breast ☐ RIGHT ☐ LEFT

CHEST
- ☐ Chest

OTHER (please specify)
- ☐ Non-Vascular Extremity Other__________________________
- ☐ Groin/Hernia __________________________________
- ☐ Palpable Lump (designated area to be evaluated)________________
- ☐ MSK (please specify)__________________________

FOR ABI's CONTACT VIR @ 444-5194

MALE PELVIS
- ☐ Testes (with blood flow Doppler evaluation if needed)
- ☐ Pelvis ☐ Pelvis– Post Void Residual only
- ☐ Prostate ☐ Prostate Bx

FEMALE PELVIS
- ☐ Transabdominal (with Transvaginal and/or Doppler eval. if needed)
- ☐ Transvaginal (with Doppler evaluation if needed)
- ☐ OB (less than 14 weeks) LMP ______________________________
- ☐ OB (greater than 14 weeks) EDD______________________________
- ☐ OB limited ____
- ☐ OB other____
- ☐ Pelvis for Post Void Residual only

VASCULAR-VENOUS
- ☐ Lower Extremity ☐ RIGHT ☐ LEFT ☐ BILATERAL
- ☐ Upper Extremity ☐ RIGHT ☐ LEFT ☐ BILATERAL

VASCULAR-ARTERIAL
- ☐ Carotid
- ☐ Lower Extremity Arterial ☐ RIGHT ☐ LEFT ☐ BILATERAL

CEREBROVASCULAR
- ☐ Transcranial Doppler Complete
- ☐ Transcranial Doppler Emboli WO Microbubble Injection
- ☐ Transcranial Doppler Emboli W Microbubble Injection

R A D I O L O G Y

GENERAL RADIOLOGY

EXTREMITY ☐ RIGHT ☐ LEFT
- ☐ Hand
- ☐ Wrist
- ☐ Forearm
- ☐ Elbow
- ☐ Humerus
- ☐ Shoulder
- ☐ Clavicle
- ☐ Scapula
- ☐ Pelvis
- ☐ Hip
- ☐ Femur
- ☐ Knee
- ☐ Tibia/Fibula
- ☐ Ankle
- ☐ Foot

☐ **BONE DENSITY DEXA HT:**__________**WT:**__________

ORDER COMMENTS: ______________________________________
____
____

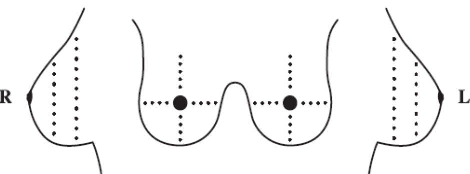
- ☐ Chest specify:________________
- ☐ Ribs ☐ RIGHT ☐ LEFT
- ☐ Foreign Body
- ☐ Abdomen
  - ☐ Flat & Upright
  - ☐ Kidney/Ureters/Bladder(KUB)
- ☐ Spine
  - ☐ Cervical
  - ☐ Lumbar
  - ☐ Thoracic
  - ☐ Thoracolumbar
  - ☐ Scoliosis
- ☐ Sinus
- ☐ Bone Survey
- ☐ Metastatic Bone Series
- ☐ Scanogram
- ☐ Shunt Series

GI/FLUORO STUDIES
- ☐ Barium Enema
  - ☐with air ☐without air
- ☐ Barium Swallow
- ☐ Modified Barium Swallow w/Speech Pathology
- ☐ Pouch-o-gram
- ☐ Small Bowel
- ☐ Upper GI
- ☐ Defecogram

GU STUDIES
- ☐ VCUG
- ☐ Retrograde urethrogram
- ☐ Urethrogram
- ☐ Cystogram
- ☐ Loopogram

☐ Other: ______________________________

BREAST IMAGING



Date of last exam:____________
- ☐ RIGHT ☐ LEFT
- ☐ Ultrasound Guided Biopsy
- ☐ Cyst Aspiration
- ☐ Fine Needle Aspiration
- ☐ Stereotactic Biopsy
- ☐ Consultation w/imaging or biopsy prn

- ☐ Screening Mammography
- ☐ Mammography Diagnostic Bilateral/PRN Ultrasound
- ☐ Mammography Diagnostic Unilateral/PRN Ultrasound
  - ☐ RIGHT ☐LEFT
- ☐ Bilateral Breast Ultrasound
- ☐ Breast Ultrasound
- ☐ RIGHT ☐ LEFT

Location: ______________________________