

THIS PHYSICIAN ORDER MUST BE PRESENTED AT THE TIME OF SERVICE



Please select if you have a location preference:

- The Miriam Hospital
 Miriam Diagnostic Imaging Center (195 Collyer St)
 Rhode Island Hospital
 Medical Office Center Building (MOC)

Please contact patient to make appointment Yes No

- STAT ROUTINE

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
 Gamma Knife
 Brain CTA

CT FACE

- Sinus Orbits
 Face Sialogram

CT NECK

- Neck Neck CTA
 Cervical Spine - Levels _____

CT CHEST

- Chest
 High Resolution Chest
 Sternum/Sternoclavicular joints
 Chest aortic dissection
 Pulmonary embolus
 Chest CTA M2S Study

CT SPINE

- Cervical Spine
 Thoracic Spine
 Lumbar Spine
 Post Myelogram _____ spine

SPECIALTY EXAMS

- CT Virtual Colonoscopy
 CT Enterography
 EKG Gated Coronary CTA
 Pulmonary Vein Map

CT ABDOMEN & PELVIS

- Abdomen & Pelvis
 Renal/Ureter Stone
 Hematuria
 CT ABDOMEN ONLY
 Abdomen ONLY (no pelvis)
 Liver Adrenal
 Pancreas Kidney
 Renal CTA
 Abdomen CTA M2S Study

CT PELVIS ONLY

- Pelvis ONLY (no abdomen)
 Acetabulum/hips
 Sacrum/Coccyx
 Pelvis CTA M2S Study

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
 Other _____

CT SCAN

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

MR BODY

- Chest: _____ Adrenals
 Liver: _____ Kidneys
 MRCP/Pancreas
 Abdomen: _____
 Pelvis: _____
 MR Enterography (Abdomen+Pelvis Study)

MRA BODY

- MRA Chest: _____
 MRA Abdomen: _____
 MRA Pelvis: _____
 MRA Peripheral: _____

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

MRA Extremity

Please specify: _____

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

**If patient has a pacemaker or is Pregnant please contact MRI and speak with an attending Radiologist at 401-444-4881

Will patient require anesthesia? YES NO If yes, please fill out sedation form

If patient has any of the following conditions, the patient will need a creatinine level drawn within 6 weeks of appointment.

- YES NO Over 60 years old
 YES NO Hypertension or taking medication for high blood pressure
 YES NO Renal Disease or transplant
 YES NO Diabetes
 YES NO Dialysis

Creatinine Level within six weeks: _____ Date of labs: _____ eGFR (if <60): _____

MRI



Please select if you have a location preference:

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

Please contact patient to make appointment Yes No
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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
Prostate
Prostate Bx
Pelvis - Post Void Residual only

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-VEINUS

- Lower Extremity - Unilateral RIGHT LEFT
Lower Extremity - Bilateral
Upper Extremity - Unilateral RIGHT LEFT
Upper Extremity - Bilateral

VASCULAR-ARTERIAL

- Carotid
Lower Extremity Arterial-Unilateral RIGHT LEFT
Lower Extremity Arterial -Bilateral

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

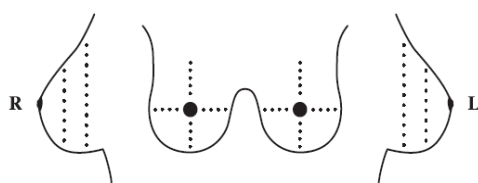
- Barium Enema
with air without air
Barium Swallow
Small Bowel
Upper GI
Defecogram

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
Needle Localization
Consultation w/imaging or biopsy prn
Galactogram

- Screening Mammography
Mammography Diagnostic Bilateral PRN Ultrasound
Mammography Diagnostic Unilateral RIGHT LEFT PRN Ultrasound
Limited Breast Ultrasound for Clinical Findings RIGHT LEFT
Complete Breast Ultrasound for screening dense breast

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