



# SouthSound RADIOLOGY

www.southsoundradiology.com

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(360) 493-4646 or 1-800-624-9759 / FAX (360) 493-5326

## DIAGNOSTIC IMAGING OUTPATIENT ORDER FORM

- Call PT to schedule appt.     PT to call & schedule appt.  
 Walk In     Priority     Routine  
 FAX BACK w/: DATE \_\_\_\_\_ TIME \_\_\_\_\_  
**ALL EXAMS ROUTINE UNLESS CHECKED BELOW**  
 FAX Immediately (2 hrs aft exam)     FAX Report  
 PT to return with Images/FAX Report Immediately

EXAM DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_ TIME \_\_\_\_\_

PATIENT NAME (Last, First, M.I.) \_\_\_\_\_ GENDER M \_\_\_\_ F \_\_\_\_

PT's D.O.B. \_\_\_\_\_ SSN \_\_\_\_\_ HOME PHONE \_\_\_\_\_ WORKPHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY, STATE, ZIP \_\_\_\_\_

INSURANCE \_\_\_\_\_ CC: \_\_\_\_\_ SERUM CREATININE RESULTS \_\_\_\_\_ DATE \_\_\_\_\_ LAB \_\_\_\_\_

HISTORY / SYMPTOM(S) \_\_\_\_\_

### CT OR MRI CONTRAST AT DISCRETION OF RADIOLOGIST?    YES    NO

PHYSICIAN/PROVIDER \_\_\_\_\_ Signature \_\_\_\_\_ Printed Name \_\_\_\_\_

#### MRI / MRA

##### Contrast at discretion of Radiologist    YES    NO

- |  |  |    |    |
|--|--|----|----|
| <input type="checkbox"/> Brain   | <input type="checkbox"/> Shoulder      | Lt | Rt |
| <input type="checkbox"/> Brain MRA                                     | <input type="checkbox"/> MR arthrogram |    |    |
| <input type="checkbox"/> MRA Neck (Carotids)                           | shoulder                               | Lt | Rt |
| <input type="checkbox"/> MRA _____                                     | <input type="checkbox"/> Forearm       | Lt | Rt |
| <input type="checkbox"/> Soft tissue neck                              | <input type="checkbox"/> Elbow         | Lt | Rt |
| <input type="checkbox"/> C-spine                                       | <input type="checkbox"/> Wrist         | Lt | Rt |
| <input type="checkbox"/> T-spine                                       | <input type="checkbox"/> Hand          | Lt | Rt |
| <input type="checkbox"/> L-spine                                       | <input type="checkbox"/> Femur         | Lt | Rt |
| <input type="checkbox"/> Chest   | <input type="checkbox"/> Knee          | Lt | Rt |
| <input type="checkbox"/> Breast  | <input type="checkbox"/> Foot          | Lt | Rt |
| <input type="checkbox"/> Abdomen                                       | <input type="checkbox"/> Ankle         | Lt | Rt |
| <input type="checkbox"/> MRCP  | <input type="checkbox"/> TMJ           | Lt | Rt |
| <input type="checkbox"/> Pelvis <b>OR</b> <input type="checkbox"/> Hip | <input type="checkbox"/> Other _____   | Lt | Rt |

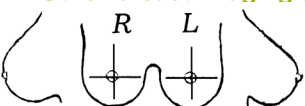
#### CT

##### Contrast at discretion of Radiologist    YES    NO

- |   |   |
|---|---|
| <input type="checkbox"/> Brain  | <input type="checkbox"/> C-spine              |
| <input type="checkbox"/> Orbit-temp bones                                   | <input type="checkbox"/> T-spine levels _____ |
| <input type="checkbox"/> Sinus -- <input type="checkbox"/> 4-view screening | <input type="checkbox"/> L-spine              |
| <b>OR</b> <input type="checkbox"/> coronal full                             | <input type="checkbox"/> Upper extr. _____    |
| <input type="checkbox"/> Soft-tissue neck                                   | <input type="checkbox"/> Lower extr. _____    |
| <input type="checkbox"/> Chest  | <input type="checkbox"/> CT colonography      |
| <input type="checkbox"/> Abdomen & pelvis                                   | <input type="checkbox"/> CT herniagram        |
| <input type="checkbox"/> Abdomen  | <input type="checkbox"/> Nerve root injection |
| <input type="checkbox"/> Pelvis   | Levels: _____ Lt    Rt                        |
| <input type="checkbox"/> KUB-ABD 1WV  | <input type="checkbox"/> Other _____          |

#### MAMMOGRAPHY

- |   |  |
|---|--|
| <input type="checkbox"/> Breast Consult   | <input type="checkbox"/> Stereotactic Bx |
| <input type="checkbox"/> Screening  | <input type="checkbox"/> Ultrasound      |
| <input type="checkbox"/> Problem solving  | <input type="checkbox"/> Ductogram       |
| <input type="checkbox"/> Unilateral   | <input type="checkbox"/> Other _____     |
| <input type="checkbox"/> Needle loc   |  |
| <input type="checkbox"/> <b>Other breast imaging at Radiologist discretion.</b> |  |



Document Palp Abn  
O'clock \_\_\_\_\_  
N+ \_\_\_\_\_

#### X-RAY

- |  |   |    |    |
|--|---|----|----|
| <input type="checkbox"/> Orbits for foreign body                   | <input type="checkbox"/> Toes   | Lt | Rt |
| <input type="checkbox"/> Sinus waters view                         | <input type="checkbox"/> Abd 1V <input type="checkbox"/> 2V                                     |    |    |
| <input type="checkbox"/> Sinus complete                            | <input type="checkbox"/> C-spine 2V   |    |    |
| <input type="checkbox"/> Chest 2V <input type="checkbox"/> 1V (PA) | <input type="checkbox"/> C-spine w/oblique  |    |    |
| <input type="checkbox"/> Ribs                                      | <input type="checkbox"/> C-spine obl, flex & extension  |    |    |
| <input type="checkbox"/> Shoulder                                  | <input type="checkbox"/> T-spine  |    |    |
| <input type="checkbox"/> Humerus                                   | <input type="checkbox"/> L-spine 2V   |    |    |
| <input type="checkbox"/> Elbow                                     | <input type="checkbox"/> L-spine w/oblique  |    |    |
| <input type="checkbox"/> Forearm                                   | <input type="checkbox"/> L-spine w/flex & extension   |    |    |
| <input type="checkbox"/> Wrist                                     | <input type="checkbox"/> Epidural inj    Level: _____   |    |    |
| <input type="checkbox"/> Hand                                      | <input type="checkbox"/> Facet injection  |    |    |
| <input type="checkbox"/> Finger                                    | Levels: _____ Lt    Rt  |    |    |
| <input type="checkbox"/> Hip                                       | <input type="checkbox"/> Nerve root injection   |    |    |
| <input type="checkbox"/> Pelvis AP                                 | Levels: _____ Lt    Rt  |    |    |
| <input type="checkbox"/> Femur                                     | <input type="checkbox"/> IVP  |    |    |
| <input type="checkbox"/> Knee                                      | <input type="checkbox"/> UGI <input type="checkbox"/> w/SBFT <input type="checkbox"/> SBFT only |    |    |
| <input type="checkbox"/> Tib/Fib                                   | <input type="checkbox"/> Barium enema <input type="checkbox"/> BE w/air                         |    |    |
| <input type="checkbox"/> Ankle                                     | <input type="checkbox"/> Barium swallow (esophagram)  |    |    |
| <input type="checkbox"/> Foot                                      | <input type="checkbox"/> Other _____  |    |    |

#### DEXA

- Bone density

#### ULTRASOUND

- |   |   |
|---|---|
| <input type="checkbox"/> OB complete  | <input type="checkbox"/> Pelvic / Pelvic TV         |
| <input type="checkbox"/> OB limited   | <input type="checkbox"/> Hysterosonography          |
| <input type="checkbox"/> OB bio profile   | <input type="checkbox"/> Breast Consult             |
| <input type="checkbox"/> Abdomen complete                                       | <input type="checkbox"/> Breast                     |
| <input type="checkbox"/> Gallbladder  | <input type="checkbox"/> Breast Bx                  |
| <input type="checkbox"/> Aorta (for AAA)  | <input type="checkbox"/> Breast Cyst Asp            |
| <input type="checkbox"/> Renal  | <input type="checkbox"/> Vascular DVT               |
| <input type="checkbox"/> Bladder Pre / Post void                                | <input type="checkbox"/> Thyroid / neck soft tissue |
| <input type="checkbox"/> Testicular   | <input type="checkbox"/> Thyroid Bx                 |
| <input type="checkbox"/> Other _____  | <input type="checkbox"/> Carotids                   |
| <input type="checkbox"/> <b>Other breast imaging at Radiologist discretion.</b> |   |

*If you are unable to keep your appointment, please give 24-hour notice.*

**MRI / CT – Please arrive 30 minutes prior to exam.**  
**All other exams, please arrive 15 minutes prior to exam time.**

## EXAMINATION PREPARATION

- Abdominal Ultrasound ..... Night before exam: Fat-free dinner. Non-fat liquids permitted until 6 hours prior to exam. Then nothing by mouth.
- Biophysical Ultrasound ..... No preparation required.
- CT ..... Please telephone South Sound Radiologists as soon as you are aware of your appointment to review exam instructions. Certain conditions warrant special instruction. If you are taking glucophage, metformin or glucovance—immediately alert SSR Schedulers of this fact.
- Colon X-Ray..... Two days **prior** to exam -- Clear liquids after 12 noon.  
(Barium Enema) One day **prior** to exam -- Purchase Colyte (a prescription item) and begin drinking at 3 PM according to manufacturer's directions. Drink the entire solution. If you feel full or nauseated, ..... wait 30 minutes and start again.
- Gallbladder Ultrasound..... Night before exam: Fat free dinner. Non-fat liquids permitted until 6 hours prior to exam. Then nothing by mouth.
- Kidney X-Ray..... Day of exam: Nothing to eat or drink after midnight. Please telephone South Sound  
(IVP) Radiologists as soon as you are aware of your appointment to review exam instructions. Certain conditions warrant special instruction. If you are taking glucophage, metformin or glucovance—immediately alert SSR Schedulers of this fact.
- Mammography ..... Use no perfume, body powder, or deodorant on the day of the exam. You will be asked to undress from the waist up for this exam. Please **wear a 2-piece outfit** the day of your scheduled appointment.
- JOINT/SPINE INJECTIONS .... ATTENTION: IF YOU ARE A PATIENT ON BLOOD THINNERS AND HAVING ONE**  
& BIOPSIES ..... **OF THESE PROCEDURES, YOU WILL NEED TO CALL FOR PREPARATION INSTRUCTIONS.**
- OB Ultrasound
  - 1<sup>st</sup> Trimester..... One-hour and fifteen minutes **prior** to exam:
    - 1) Empty your bladder;
    - 2) Drink 1-quart water within the next 15 minutes;
    - 3) Do not empty your bladder again.
  - 2<sup>nd</sup> Trimester ..... One-hour and fifteen minutes **prior** to exam:
    - 1) Empty your bladder;
    - 2) Drink 18-24 oz. water within the next 15 minutes;
    - 3) Do not empty your bladder again.
  - 3<sup>rd</sup> Trimester ..... One-hour and fifteen minutes **prior** to exam:
    - 1) No preparation required.
  - Pelvic Ultrasound..... One-hour and fifteen minutes **prior** to exam:
    - 1) Empty your bladder;
    - 2) Drink 1-quart water within the next 15 minutes;
    - 3) Do not empty your bladder again.
- Stomach X-Ray (UGI)..... Day of Exam: Nothing to eat, drink or smoke after midnight or for 6 hours before your exam.
- DEXA..... Day of Exam: No vitamins. Wear metal-free clothing.
- OTHER \_\_\_\_\_

If you are scheduled for an IVP, CT or MRI exam, biopsy or aspiration --  
please telephone South Sound Radiologists at (360) 493-4600 *OR*  
1-800-624-9759 as soon as you are aware of your appointment.  
Certain conditions warrant special instruction.

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**South Sound Radiologists' FAX # 360-493-5326**