UPMC Touchstone MEDICAL IMAGING

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## SCHEDULED APPOINTMENT:

Date:_____ Time:_____

Patient Name: _____ DOB: _____ Phone:_____ Cell:_____

Diagnosis w/ICD10 Code: _____

Symptoms:_____ ❑ Call Report STAT _____
Cell #

**Fax order, patient demographics, insurance card, and clinical notes pertaining to exam.**

### Referring Physician Signature Required Below

**Referring Dr. Signature:** _____ Date: _____

Referring Physician (Printed): _____ Contact Name: _____ Phone: _____

## MRI & MRA

- ☐ Brain
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine
- ☐ Sacrum
- ☐ Soft Tissue
- ☐ Chest
- ☐ Abdomen
- ☐ Pelvis
- ☐ TMJs

- ☐ Shoulder ☐ L ☐ R ☐ w/ Arthrogram
- ☐ Elbow ☐ L ☐ R ☐ w/ Arthrogram
- ☐ Wrist ☐ L ☐ R ☐ w/ Arthrogram
- ☐ Hand ☐ L ☐ R
- ☐ Finger ☐ L ☐ R ☐ w/ Arthrogram ____ Digit No.
- ☐ Hip ☐ L ☐ R ☐ w/ Arthrogram
- ☐ Knee ☐ L ☐ R ☐ w/ Arthrogram
- ☐ Ankle ☐ L ☐ R
- ☐ Foot ☐ L ☐ R
- ☐ Extremity ☐ L ☐ R _____ (specify site)

- ☐ MR Angiogram (MRA)
  - ☐ Brain
  - ☐ Carotids/Neck
  - ☐ Renals
  - ☐ Aorta
- ☐ Other
  _____
  _____
  _____

## CT & CTA

- ☐ Brain
- ☐ Temporal Bones & Skull Base (HRCT)
- ☐ Maxillofacial Bones
- ☐ Orbits
- ☐ Mandible
- ☐ Paranasal Sinuses
- ☐ Soft Tissue Neck
- ☐ Chest
- ☐ HRCT Chest (High Resolution)
- ☐ Abdomen and Pelvis
- ☐ Abdomen and Pelvis for Urolithiasis

- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine
- ☐ Sacrum
- ☐ Sternum
- ☐ Orthopedic Extremity CT w/ Tomographic Reconstructions (Prep 1)
  _____ (specify site)
  ☐ L ☐ R ☐ w/ Arthrogram
- ☐ Post Discography CT w/ Reconstructions (Prep 1)
  _____ level

- ☐ CT Angiogram (Prep 5)
  - ☐ Brain
  - ☐ Carotids/Neck
  - ☐ Aorta
  - ☐ Aorta w/ run off
  - ☐ Renals
- ☐ Other
  _____
  _____
  _____

## ULTRASOUND

- ☐ Complete Abdomen
- ☐ RUQ Abdomen
- ☐ Renal
- ☐ Aorta
- ☐ Scrotum/Testicular
- ☐ Prostate
- ☐ Thyroid
- ☐ Soft Tissue, Superficial
- ☐ Pelvic Transabdominal, w/ Transvaginal, prn
- ☐ Transabdominal Pelvic

- ☐ Pelvic Transvaginal
- ☐ Obstetrical w/ Transvaginal, prn
- ☐ Obstetrical Transvaginal
- ☐ Fetal Biophysical Profile
- ☐ Follicle Study
  - ☐ initial, transabdominal & transvaginal
  - ☐ follow-up, transvaginal
- ☐ Breast ☐ L ☐ R ☐ Bilateral under 30 year
- ☐ Pediatric Pelvis, Transabdominal
- ☐ Pediatric Duplex Doppler, Bilateral
- ☐ Arterial Duplex Doppler, Lower Extremity
  ☐ L ☐ R ☐ Bilateral

- ☐ Arterial Duplex Doppler, Upper Extremity
  ☐ L ☐ R ☐ Bilateral
- ☐ Abdominal Doppler
- ☐ Renal Arterial Doppler
- ☐ Venous Duplex Doppler, Lower Extremity
  ☐ L ☐ R ☐ Bilateral
- ☐ Venous Duplex Doppler, Upper Extremity
  ☐ L ☐ R ☐ Bilateral
- ☐ Duplex Doppler
- ☐ Other
  _____
  _____

## X-RAY

☐ Exam Requested _____ ☐ L ☐ R



Our center requires BUN and Creatnine Bloodwork within the last eight (8) weeks if over 65 years of age.