

Mail CD to Office

PT to return w/ CD

**STAT ORDER**

TODAY'S DATE: \_\_\_\_\_

PATIENT NAME (Last, First, M.I.): \_\_\_\_\_ PT's D.O.B: \_\_\_\_\_

PHONE: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

INSURANCE: \_\_\_\_\_ ID #: \_\_\_\_\_ AUTHORIZATION #: \_\_\_\_\_

IS EXAM DUE TO INJURY?  YES  NO Date of Injury: \_\_\_\_\_ ICD 10: \_\_\_\_\_

HISTORY/Relevant Clinical Diagnosis: \_\_\_\_\_

SYMPTOM(S) / SIGN(S): \_\_\_\_\_

PROVIDER: \_\_\_\_\_  
Signature Printed Name Date

Contrast Exams require a Creatinine lab within the past 30 days DATE: \_\_\_\_\_ LAB: \_\_\_\_\_

**MRI / MRA** Circle IV Contrast or Indicate at Rad's Discretion

W/O \_\_\_\_\_ W/ & W/O \_\_\_\_\_ or at Rad's discretion \_\_\_\_\_

<input type="checkbox"/> Brain	<input type="checkbox"/> MRCP	
<input type="checkbox"/> Orbits	<input type="checkbox"/> Shoulder	Lt Rt
<input type="checkbox"/> IAC	<input type="checkbox"/> MR arthrogram	Lt Rt
<input type="checkbox"/> MRA Brain		
<input type="checkbox"/> MRA Neck (Carotids)	<input type="checkbox"/> Forearm	Lt Rt
<input type="checkbox"/> MR Angiogram	<input type="checkbox"/> Elbow	Lt Rt
<input type="checkbox"/> MR Venogram	<input type="checkbox"/> Wrist <input type="checkbox"/> Hand	Lt Rt
<input type="checkbox"/> Soft tissue neck	<input type="checkbox"/> Femur	Lt Rt
<input type="checkbox"/> C-spine	<input type="checkbox"/> Knee	Lt Rt
<input type="checkbox"/> T-spine	<input type="checkbox"/> Ankle	Lt Rt
<input type="checkbox"/> L-spine	<input type="checkbox"/> Hind Foot	Lt Rt
<input type="checkbox"/> Chest	<input type="checkbox"/> Fore Foot	Lt Rt
<input type="checkbox"/> Breast	<input type="checkbox"/> Pelvis <input type="checkbox"/> Hip	Lt Rt
<input type="checkbox"/> Breast Implant Eval	<input type="checkbox"/> TMJ	Lt Rt
<input type="checkbox"/> Breast Biopsy	<input type="checkbox"/> Prostate	
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Other _____	

**CT / CTA**

W/ \_\_\_\_\_ W/O \_\_\_\_\_ W/ & W/O \_\_\_\_\_ or at Rad's discretion \_\_\_\_\_

<input type="checkbox"/> Brain	<input type="checkbox"/> Facial bones	<input type="checkbox"/> C-spine
<input type="checkbox"/> Orbits	<input type="checkbox"/> Temp bones/IAC	<input type="checkbox"/> T-spine levels
<input type="checkbox"/> Sinus		<input type="checkbox"/> L-spine
<input type="checkbox"/> Soft-tissue neck		<input type="checkbox"/> Upper extr. _____
<input type="checkbox"/> Chest		<input type="checkbox"/> Lower extr. _____
<input type="checkbox"/> Abdomen & pelvis		<input type="checkbox"/> Post Myelogram CTL
<input type="checkbox"/> Abdomen Upper Quadrant		<input type="checkbox"/> Low Dose Lung Cancer Screening
<input type="checkbox"/> Pelvis Lower Quadrant	<input type="checkbox"/> CTA Head <input type="checkbox"/> CTA Neck	
<input type="checkbox"/> CTA Chest <input type="checkbox"/> CTA Abd/Pelv	<input type="checkbox"/> Other _____	
<input type="checkbox"/> KUB w/ 1 view ABD x-ray		

**ULTRASOUND**

<input type="checkbox"/> OB < 14, <input type="checkbox"/> TV if needed	<input type="checkbox"/> Bladder pre/post void
<input type="checkbox"/> OB Follow Up	<input type="checkbox"/> Testicles
<input type="checkbox"/> OB BPP	<input type="checkbox"/> Hernia _____
<input type="checkbox"/> Pelvis Transabdominal only	<input type="checkbox"/> Musculoskeletal _____
<input type="checkbox"/> Pelvis Transvaginal & Transabdominal	<input type="checkbox"/> Carotids
<input type="checkbox"/> Pelvis Transvaginal Only	<input type="checkbox"/> Aorta <input type="checkbox"/> AAA <input type="checkbox"/> Screening
<input type="checkbox"/> Abdomen complete	<input type="checkbox"/> Vascular DVT
<input type="checkbox"/> RUQ/Gallbladder/Liver	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Liver elastography	<input type="checkbox"/> Neck soft tissue
<input type="checkbox"/> Abdomen vascular study	<input type="checkbox"/> Biopsy <input type="checkbox"/> Thyroid <input type="checkbox"/> Lymph
<input type="checkbox"/> Renal	<input type="checkbox"/> Hysterosonogram node
<input type="checkbox"/> Renal Arterial study	<input type="checkbox"/> Other _____

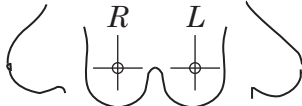
**X-RAY**

<input type="checkbox"/> Orbits for foreign body	<input type="checkbox"/> Abd 1V <input type="checkbox"/> 2V
<input type="checkbox"/> Sinus waters view <input type="checkbox"/> complete	<input type="checkbox"/> C-spine 2V
<input type="checkbox"/> Chest 2V <input type="checkbox"/> 1V (PA)	<input type="checkbox"/> C-Spine w/oblique 4V
<input type="checkbox"/> Ribs Lt Rt	<input type="checkbox"/> C-spine, flex & ext. 4V
<input type="checkbox"/> Shoulder Lt Rt	<input type="checkbox"/> T-spine
<input type="checkbox"/> Humerus Lt Rt	<input type="checkbox"/> L-spine 2V
<input type="checkbox"/> Elbow Lt Rt	<input type="checkbox"/> L-spine w/oblique 4V
<input type="checkbox"/> Forearm Lt Rt	<input type="checkbox"/> L-spine w/flex & ext. 4V
<input type="checkbox"/> Wrist <input type="checkbox"/> Hand Lt Rt	<input type="checkbox"/> Epidural inj Level: _____
<input type="checkbox"/> Finger Lt Rt	<input type="checkbox"/> TF Epidural
<input type="checkbox"/> Hip Lt Rt	<input type="checkbox"/> Facet injection Lt Rt
<input type="checkbox"/> Pelvis AP Lt Rt	Levels: _____
<input type="checkbox"/> Femur Lt Rt	<input type="checkbox"/> Nerve root injection Lt Rt
<input type="checkbox"/> Knee Lt Rt	Levels: _____
<input type="checkbox"/> Tib/Fib Lt Rt	<input type="checkbox"/> Joint Injection _____
<input type="checkbox"/> Foot <input type="checkbox"/> Ankle Lt Rt	
<input type="checkbox"/> Heel <input type="checkbox"/> Toes Lt Rt	

**BREAST IMAGING**

<input type="checkbox"/> Screening Mammography	<input type="checkbox"/> Ultrasound Breast Cyst Asp
<input type="checkbox"/> Diagnostic Mammography	<input type="checkbox"/> Needle Loc
(Breast Ultrasound If Indicated)	<input type="checkbox"/> Consult/Add views if needed
<input type="checkbox"/> Breast Ultrasound	
<input type="checkbox"/> Biopsy w/ post biopsy mammogram	

*Other breast imaging at radiologist's discretion including breast ultrasound*  NO  YES



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

**HAVE PRIORS SENT TO OUR OFFICE.**

For more information, please visit [www.southsoundradiology.com](http://www.southsoundradiology.com)

If you are scheduled for a CT or MRI exam, biopsy or aspiration -- please call South Sound Radiology at (360) 252-9301 as soon as you are aware of your appointment. Certain conditions warrant special instruction.

## EXAMINATION PREPARATION

- CT Please telephone South Sound Radiology as soon as you are aware of your appointment to review exam instructions. Certain conditions warrant special instruction.
- MRI Please telephone South Sound Radiology as soon as you are aware of your appointment to review exam instructions. Certain conditions warrant special instruction. Wear metal-free clothing and leave valuables at home.
- JOINT/SPINE INJECTION & BIOPSIES ATTENTION: IF YOU ARE A PATIENT ON BLOOD THINNERS AND HAVING ONE OF THESE PROCEDURES, YOU WILL NEED TO CALL FOR PREPARATION INSTRUCTIONS.
- 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.

## ULTRASOUND

### PLEASE DO NOT BRING CHILDREN TO YOUR APPOINTMENT.

- Abdominal Ultrasound For AM appointments do not eat or drink for 8 hours prior to exam. \*If medication requires water a few sips are acceptable. If you are insulin dependent please check with your provider for prep instructions.
- Aorta Ultrasound For AM appointments do not eat or drink for 8 hours prior to exam. \*If medication requires water a few sips are acceptable. If you are insulin dependent please check with your provider for prep instructions.
- Gallbladder/RUQ Ultrasound For AM appointments do not eat or drink for 8 hours prior to exam. \*If medication requires water a few sips are acceptable. If you are insulin dependent please check with your provider for prep instructions.
- Pelvis Ultrasound
  - 1) Drink 32 ounces of water, finish 40 minutes prior to your exam time.
  - 2) Do not empty your bladder until told to.
- Renal/Bladder Ultrasound
  - 1) Empty your bladder;
  - 2) Drink 32 ounces of water, finish 40 minutes prior to your exam time.
  - 3) Do not empty your bladder again.

## OB Ultrasound

### PLEASE DO NOT BRING CHILDREN TO YOUR APPOINTMENT.

- 1<sup>st</sup> Trimester
  - 1) Drink 32 ounces of water, finish 40 minutes prior to your exam time.
  - 2) \*Please note that only 2 guests are allowed in the exam room.
- 2<sup>nd</sup> Trimester
  - 1) Drink 32 ounces of water, finish 40 minutes prior to your exam time.
- 3<sup>rd</sup> Trimester No preparation required.
- Biophysical Ultrasound No preparation required.

## X-RAY

Wear metal-free clothing to your appointment.

\* PRESCRIPTION MEDICATIONS CAN BE TAKEN WITH A SMALL AMOUNT OF WATER

FOR OFFICE USE ONLY  
South Sound Radiology FAX # 360-455-5442