ELECTRA MEMORIAL HOSPITAL

RADIOLOGY ORDER FORM

PLEASE FAX TO (940) 298-1640

PATIENT INFORMATION

Patient Name : _____ DOB : _____

Phone Number: _____ Insurance: _____

Height: _____ Weight: _____ Ordering Provider: _____

Clinical History/DX: _____

COMPUTED TOMOGRAPHY	MRI
CONTRAST: ☐ Without ☐ with ☐ Without/With ☐ Per Radiologist protocol	**CONTRAST:** ☐ Without ☐ with ☐ Without/With ☐ Per Radiologist protocol
☐ Brain ATTN: ___IAC/Temporal Bone ___Orbits ☐ Sinus/Facial Bones ☐ Soft Tissue Neck ☐ Chest ☐ Abdomen Optional Organ Focused : ___Liver _____Pancreas ___Kidney ___Adrenal _____Renal/Mass ___Spleen ☐ Spine: ____Cervical ____Thoracic ____Lumbar ☐ Pelvis (Bone) ☐ Hip ___RT ___LT ☐ Extremity: _____ RT LT BILAT	☐ Brain ATTN: ___IAC/Temporal Bone ___Pituitary ___Orbits ☐ Soft Tissue Neck ☐ Brachial Plexus ___RT ___ LT ___ BILAT ☐ Spine: ____Cervical ____Thoracic ____Lumbar ☐ Upper Extremity: _____ RT LT BILAT ☐ Lower Extremity: _____ RT LT BILAT ☐ Pelvis (Soft Tissue) ☐ Pelvis (Bone/MSK) ☐ Hip ___RT ___LT ☐ Abdomen ___MRCP ___Liver ___Pancreas ___Kidney ___Adrenal ☐ MRV Brain
CTA: ☐ Brain ☐ Neck ☐ Chest (Thoracic Aorta) ☐ Abdomen ☐ Pelvis ☐ Runoff ☐ Other: _____	**MRA:** ☐ Neck ☐ Brain ☐ Chest (Thoracic Aorta) ☐ Abdominal Aorta ☐ Renal Arteries ☐ Pelvis ☐ Mesenteric Arteries ☐ Other: _____
SPECIALIZED EXAMINATIONS: ☐ Renal Stone ☐ Urogram ☐ CTA Chset for PE ☐ High Resolution Chest ☐ CT Low Dose Chest (Lung CA Screening)	
Other: _____	**Other:** _____

Physician Signature: _____ Date: _____