Posted 8-24-11

HEALTH SYSTEM

Department of Radiology
Radiology Research Order Form

Patient Name:_____

Date of Birth:_____

Medical Record Number:_____

Date of Service:_____

Physician: _____

NOTE: THIS FORM IS TO BE COMPLETED ONLY IF ITEMS ARE TO BE BILLED TO A RESEARCH STUDY

IRB: _____ **Subject ID:** _____

Name of Study: _____ **Name of Principal Investigator:**_____

Name of Study Coordinator:_____ **Telephone #:**_____ **Pager #**_____

Name of Sponsor: _____ **Special Instructions:**_____

SPECIAL SERVICE REQUEST:

- ☐ **Data Transfer to Sponsor**
- ☐ **Pre-Site Questionnaire**
- ☐ **Pantom Scan**
- ☐ **Paperwork to be Completed by Radiology**
- ☐ **Questionnaire Relating to Patient Scan**
- ☐ **Other:**

☐ **Without Contrast** ☐ **With Contrast** ☐ **Without followed with Contrast** ☐ **Signed Order in Clinic Chart**

Please note: Any exam requiring contrast administration, CT or MRI, must have a current (< 90 days) creatinine.
If renal function was abnormal, a more recent value would be required.

Completed By:_____

Physician Signature:_____

☐ **RECIST Criteria**

***Indicates Prep Required**

✓		GI/GU Imaging		
		Abdomen/KUB/Abdominal Series		
	*	Barium Swallow		
	*	Enema Barium		
	*	Enema Water Soluble		
	*	Esophogram - Modified		
	*	Esophogram - Water Soluble		
	*	IVP		
		Retrograde Urethrogram		
	*	Small Bowel Series		
		T-Tube Choleangiogram		
	*	Upper GI		
	*	Upper GI Water Soluable		
		VCUG		
		Other		
		Bone and General Imaging		
		AC Joints		
		Ankle	R	L
		Cervical Spine		
		Chest		
		Clavicle	R	L
		Elbow	R	L
		Femur	R	L
		Foot/Toe	R	L
		Forearm	R	L
		Hand/Finger	R	L
		Hip	R	L
		Humerus	R	L
		Knee	R	L
		Lower leg	R	L
		Lumbar Spine	R	L
		Mandible	R	L
		Pelvis	R	L
		Ribs		
		Scapula	R	L
		Scoliosis Series	R	L
		Shoulder		
		SI Joints	R	L
		Sinuses		
		Skull		
		Sternum		
		Thoracic Spine		
		Water's View Sinus		
		Wrist	R	L
		Other		
		Mammography		
		Breast Ultrasound		
		Core Biopsy		
		Diagnostic Mammogram		
		Pre-Operative Localization		
		Screening Mammogram		
		Ultrasound Guided Aspiration		
		Ultrasound Guided FNA		
		Other		

Clinic:_____

Contact Person: _____

Contact Phone:_____

Appt Date/Time:_____

Request must be faxed to 205 731-5688

If the patient is scheduled for an MRI, please ask the patient to call 205 502-9933 for the pre-screening MRI safety Interview.

✓		Ultrasound Imaging
	*	Abdomen
	*	Abdomen with Dopplers
	*	Aorta
		Carotid
		Diagnostic Paracentesis
		Diagnostic Thoracentesis
		Fine Needle Aspiration:
		Groin
		Lower Extremity Veins
		Mark for Liver Biopsy
		Parathyroid
		Pelvis
		Penile
		Post-Op Arm
		Renal
		Renal Transplant
		Renal with Dopplers
		Scrotal
		Soft Tissue
		Therapeutic Paracentesis
		Therapeutic Thoracentesis
		Thyroid
		Upper Extremity Veins
		Vein Mapping
		Other
		Cat Scan
		Neuro-CT
		Cervical Spine
	*	CTA (angio) Head
	*	CTA Neck
	*	Head
		Lumbar Spine
	*	Neck
	*	Orbits
	*	Maxillo/Facial (non-sinusitis)
		Sinus/ (sinusitis)
	*	Temporal Bones/IAC
		Thoracic Spine
		Chest-CT
	*	Chest
	*	Chest for PE
	*	CTA Chest
		High Resolution Chest
		Body-CT
	*	3 Phase Liver
	*	3 Phase Liver with Pelvis
	*	3 Phase Pancreas
	*	3 Phase Pancreas with Pelvis
	*	Abdomen and Pelvis
	*	Abdomen Only
	*	Adrenal
	*	CTA Abdomen and Pelvis
	*	CTA Runoff
	*	Enterography
	*	Pelvis Only
		Renal for Kidney Stones
	*	Renal Donor
	*	Renal for all other
		Musculosketal-CT
		Bony Pelvis
		Lower Extremity (specify) R L
		Sacrum
		SI Joints
		Upper Extremity (specify) R L
		Other
		3D Reconstructed Images of CT
		Pet Scan
		Whole Body PET

✓		MRI		
		Head-MRI		
		Brain		
		Facial Bones/Sinuses		
		Orbits		
		MRA (intracranial)		
		MRV		
		Cisternogram		
		CSF Flow Study		
		Perfusion		
		Spectroscopy		
		TMJ		
		Other		
		Neck-MRI		
		Cervical Spine		
		Soft Tissue Neck		
		Brachial Plexus	R	L
		MRA (Extracranial-Arch to Circle of Willis)		
		MRA Subclavian Only	R	L
		Other		
		Torso-MRI		
		Breast		
		Chest Wall (Musculoskeletal)		
		Ribs		
		Thoracic Spine		
		Abdomen		
		MRA (specify)		
		MRV (specify)		
		Body Pelvis (i.e. fibroids)		
		Bony Pelvis		
		Lumbar Spine		
		Lumbar Plexus		
		Sacrum		
		Gluteus		
		Spectroscopy		
		Other		
		Extremity-MRI		
		Ankle	R	L
		Ankle with Arthrogram	R	L
		Elbow	R	L
		Elbow with Arthrogram	R	L
		Femur/ Thigh	R	L
		Foot	R	L
		Forearm	R	L
		Hand	R	L
		Hip	R	L
		Hip with Arthrogram	R	L
		Humerus	R	L
		Knee	R	L
		Knee with Arthrogram	R	L
		MRA (specify)		
		MRV (specify)		
		Shoulder	R	L
		Shoulder with Arthrogram	R	L
		Tibia/ Fibula/Calf	R	L
		Wrist	R	L
		Wrist with Arthrogram	R	L
		Other		
		3D Reconstructed Images of MRI		

If this patient should require anxiety management for MRI, please have the physician circle the medication of choice and sign the request. Patient will need to arrive one hour prior to appointment and bring responsible driver.

Ativan 1 mg-2mg PO x 1 dose
Valium 5 mg-10 mg PO x 1 dose
Xanax 0.25 mg- 0.5 mg PO x 1 dose

_____

Physician Signature Date