McLaren GREATER LANSING

Central Scheduling
Phone: (517) 975-2695
Fax: (517) 975-2909
Mon-Fri: 8 a.m. - 5 p.m.

Main Radiology
Phone: (517) 975-6382
Fax: (517) 975-6263

Breast Care Center
Phone: (517) 975-6425

Nuclear Medicine Scheduling
Phone: (517) 975-7725

Grand Ledge Imaging
Phone: (517) 626-3100
Fax: (517) 626-3105

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Phone: _____ ☐ Male ☐ Female

Appointment Date: _____ Appointment Time: _____

Primary Insurance: _____ Secondary: _____ Authorization: _____

Diagnosis/Symptoms: _____

Rout Results to (other physician)

Name: _____ Phone: _____

Address: _____ Fax: _____

Other Instructions: _____

☐ Please call patient to schedule ☐ Patient to contact scheduling

If exam needs to be cancelled, please notify department 24 hours in advance.

Scheduled Exams/Appointment Required

☐ Arthrogram L-R (area) _____
☐ Barium Enema
☐ Barium Enema w/ Air
☐ Cholang Tube
☐ Cystogram-T
☐ Esophagus
☐ Hysterosalpingogram
☐ Myelogram
☐ Sialogram (area)
☐ Sm Bowel
☐ Upper GI
☐ Upper GI/Sm Bowel
☐ Urethrogram
☐ V.C.U.G
☐ Venogram L-R (area) _____

CT SCAN
(please also complete page 2)

☐ Abdomen
☐ Chest
☐ Chest for P.E.
☐ Chest Hi-Res
☐ C-Spine
☐ Enterography
☐ Facial
☐ Head
☐ Kidney Stone Protocol
☐ Lower Ext. (area) _____
☐ Upper Ext. (area) _____
☐ L/S Spine
☐ Maxiofacial
☐ Neck
☐ Pelvis
☐ Sinuses
☐ T-Spine
☐ Urography
☐ CTA Abdomen
☐ CTA Chest
☐ CTA Extremity
☐ CTA Head
☐ CTA Neck
☐ CTA Pelvis

MAMMOGRAM

☐ Abdomen
☐ Diagnostic Bilateral
☐ Diagnostic Unilateral
☐ Screening
☐ Add'l MAM/US if Req.

MRI
(please also complete page 3)

☐ Abdomen
☐ Brain
☐ Breast
☐ Chest
☐ C-Spine
☐ Lower Extremity (area) _____
☐ Upper Extremity (area) _____
☐ L/S Spine
☐ MRA Abdomen
☐ MRAHead
☐ MRANeck
☐ MRAPelvis
☐ MRA Renal
☐ Pelvis
☐ T-Spine
☐ Other _____

Nuclear Medicine

☐ Bone Scan (area) _____
☐ Gastric Emptying (liquid)
☐ Gastric Emptying (solid)
☐ Hida Scan
☐ Hida w/ CCK Scan
☐ Lung V/Q Scan
☐ Renal Scan
☐ Thyroid Uptake & Scan
☐ WBC Imgaing

ULTRASOUND

☐ Aorta
☐ Abdomen
☐ Breast Bilateral
☐ Upper Extremity (area) _____
☐ Pelvis
☐ Pregnancy
☐ Prostate
☐ Renal
☐ Scrotum
☐ Thyroid
☐ Carotid Doppler

Ordering Physician Signature: _____ Date: _____

Via (office Staff): _____

Corresponding visit ID Number: _____

The above named ordering physician hereby authorizes this electronic signature for this exam as evidenced by their physical signature contained in the above referenced visit ID number.

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CT:

☐ Y ☐ N Has the patient had barium in the last five days?

☐ Y ☐ N Does the patient have an iodine allergy

☐ Y ☐ N Does the patient have a previous exam related to this study?
(If yes, please instruct the patient to bring them at the time of this study so as not to delay the results.)

☐ Y ☐ N History of cancer?

☐ Y ☐ N Is the patient diabetic?
(If "Yes": If requested exam requires iodinated contrast injection, please advise ordering physician that diabetes medication containing metfromin should be stopped 48 hours prior to and 48 hours following the contrast injection.)

☐ Y ☐ N History of kidney impairment, disease, failure?

☐ Y ☐ N Is the patient in renal failure?

☐ Y ☐ N Is the patient pregnant or breast feeding?

_____ Patient weight

☐ Y ☐ N Does the patient have special needs? *(If yes, please explain)*

_____

_____

If oral contrast is needed, pick up 1-7 days prior to exam.

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MRI:

☐ Y ☐ N Does the patient have any body piercings ?

☐ Y ☐ N Does the patient have a pacemaker?

☐ Y ☐ N Does the patient wear a pain patch? *(if yes, it must be removed prior to MRI)*

☐ Y ☐ N History of brain aneurysm?

☐ Y ☐ N History of cancer?

☐ Y ☐ N History of heart surgery?

☐ Y ☐ N History of metal in eyes?

☐ Y ☐ N Is the patient diabetic?

☐ Y ☐ N Is the patient severly claustrophobic?

☐ Y ☐ N History of kidney impairment, disease, failure?

☐ Y ☐ N Is the patient on dialysis

_____ Patient weight

_____ Paitient height

☐ Y ☐ N Does the patient have special needs? *(If yes, please explain)*

_____

_____

☐ Y ☐ N Does the patient have a previous exam related to this study?
(If yes, please instruct the patient to bring them at the time of this study so as not to delay the results.)

☐ Y ☐ N Is the patient pregnant or breast feeding?

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