



McLaren Northern Michigan X-Ray Order Form

NORTHERN MICHIGAN

Patient's Name Last: _____ First: _____ MI: _____			Date of Birth ____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Is there any chance that the patient is pregnant? Y <input type="checkbox"/> N <input type="checkbox"/>		<input type="checkbox"/> STAT READ	<input type="checkbox"/> Cheboygan <input type="checkbox"/> Petoskey <input type="checkbox"/> LTPC <input type="checkbox"/> Gaylord	
Insurance Information		Patient Phone Daytime Phone: _____ Cell: _____		

Please Complete/Print/Sign and Fax to Central Scheduling: Fax 231.487.7920-Tel 231.487.3100-Toll Free 866.487.3100

Reason for Exam/Signs and Symptoms: _____

ICD-10 Code(s): _____

CHEST	UPPER EXTREMITY	LOWER EXTREMITY	SPINE
<input type="checkbox"/> Chest 2v (PA & lat)	<input type="checkbox"/> Finger(s) 1 2 3 4 5 L <input type="checkbox"/> R <input type="checkbox"/>	<input type="checkbox"/> Toe(s) 1 2 3 4 5 L <input type="checkbox"/> R <input type="checkbox"/>	<input type="checkbox"/> Cervical AP & Lat (Min. 4 views if Swimmers/Fuchs view is needed to see C-1 / C-7)
<input type="checkbox"/> Chest 1v (AP or PA)	<input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/>	<input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/>	<input type="checkbox"/> Cervical AP & Lat Only (post-op)
<input type="checkbox"/> Chest 2v w/ Apical Lordotic	<input type="checkbox"/> Bone Age L <input type="checkbox"/> R <input type="checkbox"/>	<input type="checkbox"/> Calcaneus (Heel) L <input type="checkbox"/> R <input type="checkbox"/>	<input type="checkbox"/> Cervical AP & Lat w Obliques
<input type="checkbox"/> Chest 4v (PA & lat w/obliques)	<input type="checkbox"/> Wrist L <input type="checkbox"/> R <input type="checkbox"/>	<input type="checkbox"/> Ankle Survey (2 views) L <input type="checkbox"/> R <input type="checkbox"/>	<input type="checkbox"/> Cervical Comp (w obl, flex & ext)
<input type="checkbox"/> Chest Insp & Exp w Lateral	<input type="checkbox"/> Wrist with Scaphoid View L <input type="checkbox"/> R <input type="checkbox"/>	<input type="checkbox"/> Ankle Complete (4 views) L <input type="checkbox"/> R <input type="checkbox"/>	<input type="checkbox"/> Thoracic w Swimmers View
<input type="checkbox"/> Ribs Right w PA Chest	<input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/>	<input type="checkbox"/> Tib-Fib L <input type="checkbox"/> R <input type="checkbox"/>	<input type="checkbox"/> Thoraco-Lumbar Spine
<input type="checkbox"/> Ribs Left w PA Chest	<input type="checkbox"/> Elbow Survey (AP & lat) L <input type="checkbox"/> R <input type="checkbox"/>	<input type="checkbox"/> Knee Survey (AP & lat only) L <input type="checkbox"/> R <input type="checkbox"/>	<input type="checkbox"/> Lumbar AP & Lat Only (post-op)
<input type="checkbox"/> Ribs Bilateral w PA Chest	<input type="checkbox"/> Elbow Trauma (4 views) L <input type="checkbox"/> R <input type="checkbox"/>	<input type="checkbox"/> Knee 3 Views L <input type="checkbox"/> R <input type="checkbox"/>	<input type="checkbox"/> Lumbar Lateral (Flex & Ext Only)
<input type="checkbox"/> Decubitus Chest L <input type="checkbox"/> R <input type="checkbox"/>	<input type="checkbox"/> Humerus L <input type="checkbox"/> R <input type="checkbox"/>	<input type="checkbox"/> Knee Complete (4 views) L <input type="checkbox"/> R <input type="checkbox"/>	<input type="checkbox"/> Lumbar Min. 4 Views (includes AP, AP sacrum, lat & spot)
<input type="checkbox"/> Sternum	<input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/>	<input type="checkbox"/> Femur L <input type="checkbox"/> R <input type="checkbox"/>	<input type="checkbox"/> Lumbar AP & Lat w Obliques
ABDOMEN	<input type="checkbox"/> Scapula L <input type="checkbox"/> R <input type="checkbox"/>	<input type="checkbox"/> Hip Complete L <input type="checkbox"/> R <input type="checkbox"/>	<input type="checkbox"/> Lumbar Complete w Obliques and Flex & Ext
<input type="checkbox"/> AP Single View (KUB)	<input type="checkbox"/> Clavicle L <input type="checkbox"/> R <input type="checkbox"/>	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Sacrum/Coccyx
<input type="checkbox"/> AP & Upright/Decubitus	<input type="checkbox"/> AC Joints	<input type="checkbox"/> SI Joints	<input type="checkbox"/> Neck Soft Tissue AP & Lat
<input type="checkbox"/> Acute Abd w 1v Chest	<input type="checkbox"/> Infant Upper (Under 18 mos) L <input type="checkbox"/> R <input type="checkbox"/>	<input type="checkbox"/> Infant Lower (Under 18 mos) L <input type="checkbox"/> R <input type="checkbox"/>	<input type="checkbox"/> Other (Specify in free text box)
<input type="checkbox"/> VP Shunt Evaluation	<input type="checkbox"/> Other (Specify in free text box)	<input type="checkbox"/> Other (Specify in free text box)	<input type="checkbox"/> Other (Specify in free text box)
<input type="checkbox"/> Babygram		To be Scheduled: Please Call 231.487.3100	
<input type="checkbox"/> Other (Specify in free text box)	HEAD	<input type="checkbox"/> Scoliosis Standing	<input type="checkbox"/> Leg Length L <input type="checkbox"/> R <input type="checkbox"/>
Free Text Box: (include any special instructions)	<input type="checkbox"/> Skull Complete	<input type="checkbox"/> Cystogram	<input type="checkbox"/> Lap Band Adjustment
	<input type="checkbox"/> Skull PA & Lateral	<input type="checkbox"/> Voiding Cystogram (VCUG)	<input type="checkbox"/> Bone Survey Complete
	<input type="checkbox"/> Skull for Pressure Valve Check	<input type="checkbox"/> Hysterosalpingogram	<input type="checkbox"/> T-Tube Injection
	<input type="checkbox"/> Facial Bones Complete	<input type="checkbox"/> IVP w Tomograms	<input type="checkbox"/> Sniff Test
	<input type="checkbox"/> Mandible	<input type="checkbox"/> Nephrostogram	Arthrogram No CT/MRI
	<input type="checkbox"/> Orthopantogram (Panorex)	<input type="checkbox"/> Hip Injection L <input type="checkbox"/> R <input type="checkbox"/> (please specify medications in free text box)	<input type="checkbox"/> Shoulder <input type="checkbox"/> Wrist L <input type="checkbox"/> R <input type="checkbox"/>
	<input type="checkbox"/> Nasal Bones	<input type="checkbox"/> Lumbar Puncture Under Fluoro	<input type="checkbox"/> Barium Enema Single Contrast
	<input type="checkbox"/> Orbits / Pre MRI / Foreign Body	<input type="checkbox"/> Cervical Myelogram w CT	<input type="checkbox"/> Barium Enema Air Contrast
	<input type="checkbox"/> Orbits Trauma	<input type="checkbox"/> Thoracic Myelogram w CT	<input type="checkbox"/> Water Soluble Enema
	<input type="checkbox"/> Sinuses - Waters View Only	<input type="checkbox"/> Lumbar Myelogram w CT	<input type="checkbox"/> Enema via Colostomy
	<input type="checkbox"/> Sinuses Complete	<input type="checkbox"/> Therapeutic Spinal Injection Procedure	<input type="checkbox"/> Esophagram (Barium Swallow)
	<input type="checkbox"/> Other (Specify in free text box)	In "Free Text Box", please indicate type of injection, laterality, levels or other important clinical information. Consultation with Radiologist recommended.	<input type="checkbox"/> Small Bowel Series
		<input type="checkbox"/> RFN (Please specify levels in free text)	<input type="checkbox"/> Upper GI Air Contrast (Routine)
		<input type="checkbox"/> TMJ X-Ray with tomography	<input type="checkbox"/> Upper GI Single Contrast
			<input type="checkbox"/> Video Swallow
		<input type="checkbox"/> Other (Specify in free text box)	

Form Filled out by: _____

Office Phone: _____

Today's Date & Time: _____

Exam Date & Time: _____

Physician signature: _____ (Sign after printing)

MNM 721.293 - Rev: 3/19/2018

