McLaren
GREATER LANSING

Submit

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

Radiology Scheduled Referral Form

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

Nuclear Medicine Scheduling
Phone: (517) 975-7725

MMP Imaging Center
Phone: (517) 913-3800

Breast Care Center
Phone: (517) 975-6425

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

MMP Nuclear Medicine Scheduling
Phone: (517) 975-7725

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

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

Appointment Date: _____ Appointment Time: _____

Primary Insurance: _____ Secondary: _____ Authorization: _____

Diagnosis/Symptoms: _____

Route 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
☐ Nephrostogram/Loopogram
☐ Sialogram (area)
☐ Sm Bowel
☐ Upper GI
☐ Upper GI/Sm Bowel
☐ Urethrogram
☐ V.C.U.G
☐ Venogram L-R (area) _____
☐ Other _____

CT SCAN
(please also complete page 2)

☐ Abdomen
☐ Chest
☐ Chest for P.E.
☐ Chest Hi-Res
☐ Chest LDCT - diagnostic
☐ 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 - Upper
☐ ☐ CTA Extremity - Lower
☐ CTA Head
☐ CTA Neck
☐ CTA Pelvis
☐ Other _____

MAMMOGRAM

☐ Bone Density (DXA)
☐ 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
☐ Other

Ordering Physician Signature: _____ Date: _____ Time: _____

Ordering Physician (PRINT): _____

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.***

****The above named ordering physician understands all forms sent containing PHI must be encrypted and the burden of encryption falls on the sender.***

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Radiology Scheduled Referral Form

CT:

☐ Yes ☐ No Has the patient had barium in the last five days?

☐ Yes ☐ No Does the patient have an iodine allergy

☐ Yes ☐ No 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.)

☐ Yes ☐ No History of cancer?

☐ Yes ☐ No Is the patient diabetic?
(If "Yes": If requested exam requires iodinated contrast injection and patient takes diabetes medication containing Metformin, please contact Radiology or Central Scheduling for further instructions.)

☐ Yes ☐ No History of kidney impairment, disease, failure?

☐ Yes ☐ No Is the patient in renal failure?

☐ Yes ☐ No Is the patient pregnant or breast feeding?

_____ Patient weight

_____ Patient height

☐ Yes ☐ No Does the patient have special needs? *(If yes, please explain)*

_____

_____

☐ With ☐ Without Is the test being ordered with or without contrast?
☐ With and Without

If exam requires IV contrast, GFR screening may be required.
Consult Central Scheduling for conditions which may require lab work prior to exam.

If exam requires oral contrast, please arrive 2 hours prior to exam..

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Radiology Scheduled Referral Form

MRI:

☐ Yes ☐ No Does the patient have stents or other metal implants?

☐ Yes ☐ No Does the patient have any body piercings ?

☐ Yes ☐ No Does the patient have a pacemaker?

☐ Yes ☐ No Does the patient wear a pain patch? *(if yes, it must be removed prior to MRI)*

☐ Yes ☐ No History of brain aneurysm?

☐ Yes ☐ No History of cancer?

☐ Yes ☐ No History of heart surgery?

☐ Yes ☐ No History of metal in eyes?

☐ Yes ☐ No Is the patient diabetic?

☐ Yes ☐ No Is the patient claustrophobic?

☐ Yes ☐ No History of kidney impairment, disease, failure?

☐ Yes ☐ No Is the patient on dialysis

_____ Patient weight

_____ Patient height

☐ Yes ☐ No Does the patient have special needs? *(If yes, please explain)*

_____

_____

☐ Yes ☐ No 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.)

☐ Yes ☐ No Is the patient pregnant or breast feeding?

☐ Yes ☐ No Has the patient had surgery to the exam area?

☐ With ☐ Without Is the test being ordered with or without contrast?
☐ With and Without

If exam requires IV contrast, GFR screening may be required.
Consult Central Scheduling for conditions which may require lab work prior to exam.