APPOINTMENT CENTRAL
DIAGNOSTIC IMAGING PHYSICIAN ORDER

* 1 P0 *

PATIENT INFORMATION

Last Name	First Name	MI	DOB	SEX M F
Street Address			Home Phone:	
City	State	Zip Code	Cell Phone: Other Contact Phone:	
Insurance Provider	Policy Number	Subscriber Name		

Relationship to Patient ☐ Self ☐ Spouse ☐ Dependent

Pre-Certification/ Approval #

Special Instructions: ☐ Hold & Call ☐ Send & Call ☐ Send Images

Appointment DAY- DATE- TIME

* Exams may require Pre-certification, Prior Authorization or be subject to Medical Necessity

RADIOLOGY

- ☐ Esophogram
- ☐ Modified Barium Swallow
- ☐ Upper GI Series
- ☐ Small Bowel Series
- ☐ Barium Enema
- ☐ Barium Enema with air
- ☐ VCUG
- ☐ IV Pyelogram
- ☐ Abdomen/KUB
- ☐ Pelvis
- ☐ Chest *
- ☐ Skull
- ☐ Orbits
- ☐ Nasal Bones
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine
- ☐ Scoliosis Series

	Left	Right
☐ Ribs		
☐ Finger		
☐ Hand		
☐ Wrist		
☐ Forearm		
☐ Elbow		
☐ Humerus		
☐ Shoulder		
☐ Clavicle		
☐ Infant Upper Extremity less than 12 months		
☐ Toe		
☐ Foot		
☐ Ankle		
☐ Tibia- Lower leg		
☐ Knee		
☐ Femur		
☐ Hip		
☐ Infant Lower Extremity less than 12 months		
☐ Other		

NUCLEAR MEDICINE

- ☐ Bone Scan
- ☐ Bone Scan with SPECT
- ☐ Gastric Emptying
- ☐ Hida Scan
- ☐ Hida Scan with CCK
- ☐ Liver/Spleen Scan
- ☐ Lung V/P Scan
- ☐ MUGA (Gated Cardiac) *
- ☐ Parathyroid Scan with Spect
- ☐ Renal Scan
- ☐ Renal Scan with Lasix
- ☐ Stress MIBI + Treadmill *
- ☐ Stress MIBI + Pharm. *
- ☐ Thyroid Uptake & Scan
- ☐ Other

MAMMOGRAPHY

	Left	Right	Bilat
☐ Breast Screening			
☐ Breast Diagnostic			
☐ Breast Ultrasound			
☐ Breast Ultrasound Biopsy			
☐ Breast Stereotactic Biopsy			
☐ Other			

BONE DENSITY

- ☐ Spine/Femur *
- ☐ Extremity (forearm)*
- ☐ Vertebral Fracture Assessment *
- ☐ Total Body Comp *

ULTRASOUND

- ☐ Abdomen- Complete *
- ☐ Doppler Complete-Arteries & Veins *
- ☐ Doppler Limited- Arteries & Veins *
- ☐ Limited Abdomen-Single organ, quadrant, follow-up (No kidney, aorta or IVC) *
- ☐ Pelvic-Non OB Transabdominal *
- ☐ Pelvic-Non OB Transvaginal *
- ☐ Bladder with Pre & Post Void
- ☐ Infant Hips with manipulation
- ☐ Infant Hips without manipulation
- ☐ Retroperitoneal Complete with Renal & Bladder
- ☐ IPPE-AAA Screening *
- ☐ Limited Retroperitoneal-Renal and/or Aorta, IVC, Iliacs
- ☐ Soft Tissue Extremity
- ☐ Testicular with Doppler
- ☐ Thyroid
- ☐ Thyroid Fine Needle Aspiration
- ☐ Paracentesis
- ☐ Thoracentesis
- ☐ Amniocentesis to include Measurement
- ☐ Biophysical Profile
- ☐ Cervical Length-Transvaginal
- ☐ Fetal Screen Transabdominal Greater than 14 Weeks
- ☐ Fetal Transabdominal Less than 14 Weeks
- ☐ Fetal Transvaginal Less than 10 Weeks
- ☐ Fetal Follow up
- ☐ Fetal Limited-Transabdominal
- ☐ Umbilical Artery Doppler
- ☐ Other

Additional comments:

History/Reason for Exam/Signs & Symptoms/ICD9 Code _____

Physician Signature: _____ **Physician Phone #:** _____

Copy Report to: _____

ST. JOSEPH HOSPITAL
NASHUA, NH 03061

Scheduling
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Fax: 603-578-5058

Place Label Here