

**DIAGNOSTIC IMAGING ORDER FORM**

<b>PATIENT NAME:</b> (Last, First, Middle)	Social Security #:	Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Ordering Physician Signature:	Skilled Nursing Patient:	<input type="checkbox"/> Fax results to:	Date: _____
Telephone:	Facility:	<input type="checkbox"/> Wet Read	Time: _____

**PROVIDE DIAGNOSIS/SYMPTOMS FOR ALL TESTS ORDERED:**

1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ 4) \_\_\_\_\_

<b>ABDOMEN</b>	<b>UPPER EXTREMITIES</b>		
<input type="checkbox"/> Abdomen single view	<input type="checkbox"/> AC Joints	<input type="checkbox"/> OS Calcis	<input type="checkbox"/> OTHER
<input type="checkbox"/> Abdomen with upright and PA chest	<input type="checkbox"/> Clavicle Left ___ Right ___ Bilat ___	<input type="checkbox"/> Femur Left ___ Right ___ Bilat ___	_____
<input type="checkbox"/> Abdomen with decubitus Left ___ Right ___ Bilat ___	<input type="checkbox"/> Hand Left ___ Right ___ Bilat ___	<input type="checkbox"/> Lower Leg Left ___ Right ___ Bilat ___	<b>GI PROCEDURES THESE EXAMS MUST BE SCHEDULED AT 978-521-8121</b>
<b>CHEST</b>	<input type="checkbox"/> Wrist Left ___ Right ___ Bilat ___	<input type="checkbox"/> Knee, AP & LAT Left ___ Right ___ Bilat ___	<input type="checkbox"/> Barium Enema Air. Con.
<input type="checkbox"/> PA and Lateral Chest	<input type="checkbox"/> Shoulder Left ___ Right ___ Bilat ___	<input type="checkbox"/> TOES include AP foot oblique and lateral of digit(s)  Digits: _____ Left ___ Right ___	<input type="checkbox"/> Barium Enema Colon
<input type="checkbox"/> PA Chest only	<input type="checkbox"/> Humerus Left ___ Right ___ Bilat ___		<input type="checkbox"/> Upper G.I. Series
<input type="checkbox"/> Lordotic Chest	<input type="checkbox"/> Forearm Left ___ Right ___ Bilat ___		<input type="checkbox"/> U.G.I. & Sm Bowel
<input type="checkbox"/> Chest with obliques Left ___ Right ___ Bilat ___	<input type="checkbox"/> Elbow, AP & LAT Left ___ Right ___ Bilat ___		<input type="checkbox"/> Small Bowel Series
<input type="checkbox"/> Rib series includes PA Chest Left ___ Right ___ Bilat ___	<input type="checkbox"/> Forearm Left ___ Right ___ Bilat ___	<b>NECK, HEAD AND SPINE</b>	<input type="checkbox"/> Barium Swall Eso & Pha
<input type="checkbox"/> Sternum	<input type="checkbox"/> Elbow, AP & LAT Left ___ Right ___ Bilat ___	<input type="checkbox"/> Facial Bones	<input type="checkbox"/> Modified Barium Swallow  Arrange with Speech Pathology before scheduling appointment Call: Speech Pathologist 978-686-9780
<b>DIGITAL MAMMOGRAPHY</b>	<input type="checkbox"/> Fingers includes PA hand Oblique and lateral of affected digit(s) Digits: _____ Left ___ Right ___	<input type="checkbox"/> Mandible	
<input type="checkbox"/> Bilateral Screening	<input type="checkbox"/> Fingers includes PA hand Oblique and lateral of affected digit(s) Digits: _____ Left ___ Right ___	<input type="checkbox"/> Nasal Bones	
<input type="checkbox"/> Diagnostic Mammo Left ___ Right ___ Bilat ___	<input type="checkbox"/> Fingers includes PA hand Oblique and lateral of affected digit(s) Digits: _____ Left ___ Right ___	<input type="checkbox"/> Sinuses	<b>Minor Special Procedures THESE EXAMS MUST BE SCHEDULED AT 978-521-8121</b>
<input type="checkbox"/> Breast Ultrasound (US)	<b>LOWER EXTREMITIES</b>	<input type="checkbox"/> Skull	<input type="checkbox"/> IVP
<b>Comments</b>	<input type="checkbox"/> Ankle Left ___ Right ___ Bilat ___	<input type="checkbox"/> Neck, Soft Tissues	<input type="checkbox"/> VCUg
_____	<input type="checkbox"/> Foot Left ___ Right ___ Bilat ___	<input type="checkbox"/> Thoracic (Dorsal) Spine AP & LAT	<input type="checkbox"/> Hysterosalpingogram
_____	<input type="checkbox"/> Hip AP & LAT Frog W/Pelvis Left ___ Right ___ Bilat ___	<input type="checkbox"/> Cerv Spine AP, LAT, Odontoid	<input type="checkbox"/> Arthrogram  Type: _____  MRI to follow? _____
_____	<input type="checkbox"/> Hip AP & LAT Frog W/Pelvis Left ___ Right ___ Bilat ___	<input type="checkbox"/> Cervical Spine AP, LAT, Odontoid, both obliques	
_____	<input type="checkbox"/> Hips Bi W/Latrls	<input type="checkbox"/> Lumbar Spine AP/LAT	
_____	<input type="checkbox"/> Pelvis, AP	<input type="checkbox"/> Lumbar Spine AP/LAT and both obliques	
_____		<input type="checkbox"/> Sacrum & Coccyx	