* P O 6 4 7 5 *

Charleston Area Medical Center

PLACE PATIENT IDENTIFICATION LABEL HERE

PHYSICIAN ORDERS – MEDICAL IMAGING OUTPATIENT ORDER FORM

❑ Imaging Center – Kanawha City ❑ Imaging Center – Southridge ❑ The Breast Center
❑ General Hospital ❑ Memorial Hospital ❑ Women and Children's Hospital ❑ Teays Valley Hospital

PATIENT NAME: _____ **DOB:** _____ **DAYTIME PHONE:** _____

APPOINTMENT: DATE: _____ TIME: _____ A.M. / p.m. ❑ Please call patient for appointment

PHYSICIAN INSTRUCTIONS: ❑ STAT ❑ PRE-OP Call Results: _____

CLINICAL HISTORY / INDICATIONS FOR STUDY: _____ **DIAGNOSIS:** _____

DIAGNOSTIC

❑ Scoliosis: ❑ 1 view ❑ 2 view
❑ Abdomen
❑ Chest
❑ PA & Lat ❑ AP only
❑ w/decubs ❑ Obliques
❑ Spine
❑ Cervical ❑ Thoracic
❑ Lumbar
❑ Extremity
Specify: _____
❑ R ❑ L ❑ Bilateral
❑ Other: _____

NUCLEAR MEDICINE

❑ Bone Scan – Whole Body
❑ 3-Phase
❑ Bone Scan, (*specify)* Limited
❑ Cardiac Gated -
MUGA/ Ejection Fraction
❑ Cardiac Stress Test -
❑ Treadmill
❑ Pharmacological
❑ Hepatobiliary Study –HIDA
❑ w/ CCK
❑ Lung Scan
❑ Quantitative Lung Scan
❑ Renal Scan
❑ Catopril ❑ Lasix
❑ Thyroid Scan and Uptake
❑ Gastric empty
❑ Tumor / Lymphoma
Specify: _____
❑ Other: _____

ULTRASOUND

❑ Abdomen, Complete (all organs)
❑ Abdomen, Limited(RUQ) (single organ)
❑ Biopsy *(specify)*: _____
❑ Pelvic
❑ OB ❑ GYN
❑ Transvaginal ❑Transabdominal
❑ Renal
❑ Spleen ❑ Aorta
Vascular
❑ Abdomen ❑ Carotid
❑ Arterial ❑ ABI
❑ Renal Artery
❑ Testicular
❑ Venous Doppler ❑ R ❑ L
❑ Other: _____

CT SCAN

❑ 3D-MPR Post Processing
❑ Chest (*specify contrast*)
❑ Abdomen (*specify contrast*)
❑ Pelvis (*specify contrast*)
❑ Biopsy*(specify)*:_____
❑ Extremity (*specify*): _____
❑ R ❑ L
❑ CT IVP ❑ CTA
❑ Neck / Soft Tissue
❑ Head/Brain (*specify contrast*)
❑ Facial Bones
❑ Orbits
❑ Sinus Screening
❑ Sinus
❑ Spine ❑ Cervical
❑ Thoracic ❑ Lumbar
❑ Other:_____

Specify contrast ❑ IV ❑ Oral
❑ w/ ❑ w/o ❑ w/ and w/o

FLUOROSCOPY

❑ Barium Enema
❑ w/air if needed
❑ UGI ❑ w air ❑ w /Small Bowel
❑ Barium Swallow
❑ IVP (w/Tomography,if necessary)
❑ Other:_____
❑ Myelogram
❑ Total
❑ Cervical
❑ Thoracic
❑ Lumbar
❑ CT to follow with 3D MPR
❑ Video swallow

MRI

❑ Abdomen *(specify)*:_____
❑ Brain/ Head
❑ Chest / Heart
❑ Extremity_____❑ R ❑ L
❑ Hip ❑ R ❑ L
❑ Knee ❑ R ❑ L
❑ MRA (*specify):*_____
❑ Orbits
❑ Pelvis
❑ Shoulder ❑ R ❑ L
❑ Spine ❑ Cervical
❑ Thoracic ❑ Lumbar
❑ Breast ❑ Both
❑ Right ❑ Left
❑ TMJ
❑ Other:_____

Specify contrast ❑ IV
❑ w/ ❑ w/o ❑ w/ and w/o

PET / CT SCAN

❑ Alzheimers
❑ Breast
❑ Cervical
❑ Colorectal
❑ Esophageal
❑ Head / Neck
❑ Lung
❑ Lymphoma
❑ Melanoma
❑ Ovarian cancer
❑ Pulmonary nodule
❑ Other:_____

MAMMOGRAPHY

❑ Screening Mammogram
❑ Add-views or U/S as needed
❑ Bilateral Diagnostic Mammogram
❑ Unilateral Diagnostic Mammogram ❑ R ❑ L
❑ Breast Ultrasound
❑ R ❑ L
Location:_____

BONE DENSITY

❑ Bone density lumbar / hip / pelvis
❑ Bone density vertebral fracture assessment
❑ Bone density extremity

CENTRAL SCHEDULING

Phone: *(304) 388-9677*

See back page for additional information

DATE: **(Required)** **TIME:** **(Required)** **PHYSICIAN SIGNATURE:** **(Required)**

PLEASE READ PRIOR TO YOUR EXAM: You must have any required referral or authorization numbers with you at the time of your exam. If you arrive for your exam without this information, we will attempt to get the referral / authorization number from your physician's office or insurance company, but please realize that your exam may have to be rescheduled.

PREP INSTRUCTIONS: PLEASE FOLLOW THE INSTRUCTIONS CHECKED BELOW. IF YOU HAVE ANY QUESTIONS, PLEASE CALL ***CENTRAL SCHEDULING*** at ***(304) 388-9677***.

❑ **Abdominal Ultrasound**
Nothing by mouth after midnight prior to examination.

❑ **Barium Enema (BE) or Intravenous Pyelogram (IVP)**
Pick up prep kit from Pharmacy or from physician.
Follow the instructions on the kit.

❑ **CT: All IV Contrast Studies (Head, Neck, Chest, Abdomen, Pelvis)**
Nothing by mouth after start of exam prep. No solid food.
Medications may be taken with small amounts of water.

❑ **Nuclear Medicine:** Nothing by mouth after midnight for Thyroid, HIDA, Cardiac and GI Studies.

❑ **CT Scan Abdomen / Pelvis with Oral Contrast**
Drink only oral contrast per given instructions.
Contrast can be obtained at_____.

❑ **Pelvic Ultrasound / OB Ultrasound**
Drink at least one quart of any non-carbonated beverage 1½ hours prior to examination. Do not urinate. The bladder must be full for the exam.

❑ **Upper GI Series (UGI) or Small Bowel (SB)**
Nothing to eat or drink after midnight prior to the examination.

❑ **PET:** Nothing by mouth 6 hours prior to appointment, arrive 1 hour early.
Can drink water.

IF YOU HAVE ANY QUESTIONS ABOUT THE PREPARATION FOR YOUR EXAM, PLEASE CALL LOCATION AS LISTED BELOW. PLEASE ARRIVE AT LEAST 30 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT TO ALLOW TIME TO COMPLETE THE REGISTRATION PROCESS. PLEASE BRING ANY PREVIOUS FILMS RELATING TO YOUR EXAM SO THAT OUR PHYSICIAN CAN PROPERLY EVALUATE YOUR RESULTS.

LOCATIONS AND ADDRESSES

Orders may be faxed to the performing facility registration area (see corresponding Fax number below)

CAMC Imaging Center – Kanawha City
3416 MacCorkle Ave. SE
Charleston, WV 25304
Phone: **(304) 388-1660**
Fax: (304) 388-1665

CAMC Imaging Center – Southridge
60 RHL Blvd.
South Charleston, WV 25309
Phone: **(304) 720-9729**
Fax: (304) 720-9730

CAMC General Hospital Radiology
501 Morris St.
Charleston, WV 25301
Phone: **(304) 388-6044**
Fax: (304) 388-7615

CAMC Memorial Hospital Radiology
3200 MacCorkle Ave. SE
Charleston, WV 25304
Phone: **(304) 388-5455**
Fax: (304) 388-9231

CAMC Women and Children's Hospital Radiology
800 Pennsylvania Ave.
Charleston, WV 25302
Phone: **(304) 388-2411**
Fax: (304) 388-2736

The Breast Center
Third Floor
3415 MacCorkle Ave. SE
Charleston, WV 25304
Phone: **(304) 388-2860**
Fax: (304) 388-2866

CAMC Teays Valley Hospital Radiology
1400 Hospital Dr.
Hurricane, WV 25526
Phone: **(304) 757-1790**
Fax: (304) 757-1872

MAP

Visit *camc.org* for directions to each location.