Radiology Order Form

Fax to: 405-601-4525

5800 North Portland
Oklahoma City, OK 73112
Phone: 405-601-4500

Patient Name _____ DOB _____ Phone: _____

Insurance: _____ Diagnosis _____

SEND CLINICALS FOR MRI AND CT • WE WILL OBTAIN ALL INSURANCE AUTHORIZATIONS

☐ STAT ☐ ASAP ☐ Routine Ordering Provider _____

CT Study		With Contrast	Without Contrast
☐	Abdomen (Only)	☐	☐
☐	Abdomen & Pelvis	☐	☐
☐	Brain	☐	☐
☐	Chest	☐	☐
	CTA-CT Angiogram		
	☐ Aorta	☐	☐
	☐ Brain	☐	☐
	☐ Carotids	☐	☐
	☐ Iliofemoral Runoff	☐	☐
☐	Lower Extremity ☐L ☐R	☐	☐
☐	Neck (Soft Tissue)	☐	☐
☐	Pelvis (Only)	☐	☐
☐	Sacrum- Coccyx	☐	☐
☐	Sinuses	☐	☐
	Spine		
	☐ Cervical	☐	☐
	☐ Lumbar	☐	☐
	☐ Thoracic	☐	☐
☐	Temporal Bone	☐	☐
☐	Upper Extremity ☐L ☐R	☐	☐
☐	Urogram	☐	☐
☐	Arthrogram ☐L ☐R ☐L ☐R ☐L ☐R	☐ Knee ☐ Shoulder ☐ Hip	

Bone Density	
☐	Bone Density

Echocardiogram	
☐	Echocardiogram

Ultrasound Study & Biopsy		
☐	Abdomen ☐Complete ☐Limited	
☐	Aorta	
☐	Carotid Artery	
☐	Kidney/ Bladder	
☐	Lower Extremity Venous Doppler	☐L ☐R
☐	Upper Extremity Venous Doppler	☐L ☐R
☐	Lower Extremity Arterial Doppler	☐L ☐R
☐	Upper Extremity Arterial Doppler	☐L ☐R
☐	Pelvis Transabdominal	
☐	Pelvis Transvaginal	
☐	Pelvis Complete	
☐	Pregnancy < 14 Weeks	
☐	Pregnancy > 14 Weeks	
☐	Pregnancy Limited	
☐	Pregnancy Trasvaginal	
☐	Scrotum	
☐	Thyroid	
☐	Other Soft Tissue:	
☐	Biopsy ☐ Thyroid ☐ Lymph Node ☐ Other	

MRI Study		With Contrast	Without Contrast
☐	Abdomen	☐	☐
☐	Ankle ☐L ☐R	☐	☐
☐	Brain	☐	☐
☐	Chest	☐	☐
☐	Elbow ☐L ☐R	☐	☐
☐	Foot ☐L ☐R	☐	☐
☐	Hand ☐L ☐R	☐	☐
☐	Hip ☐L ☐R	☐	☐
☐	Knee ☐L ☐R	☐	☐
☐	Lower Extremity ☐L ☐R ☐Femur ☐Tibia/Fib	☐	☐
	MRA- MR Angiogram		
	☐ Abdomen/Aorta	☐	☐
	☐ Brain	☐	☐
	☐ Carotids	☐	☐
	☐ Aorto-Iliofemoral Runoff	☐	☐
☐	MRCP	☐	☐
☐	Neck	☐	☐
☐	Orbit, Face, Neck	☐	☐
☐	Pelvis	☐	☐
☐	Sacrum- Coccyx	☐	☐
	Spine		
	☐ Cervical	☐	☐
	☐ Lumbar	☐	☐
	☐ Thoracic	☐	☐
☐	Shoulder ☐L ☐R	☐	☐
☐	TMJ Joint	☐	☐
☐	Upper Extremity ☐L ☐R	☐	☐
☐	Wrist ☐L ☐R	☐	☐
☐	Forearm ☐L ☐R	☐	☐

Breast Imaging & Procedures		
☐	Screening Mammogram	
☐	Diagnostic Bilateral Mammogram	
☐	Diagnostic Unilateral Mammogram	☐L ☐R
☐	Breast Ultrasound	☐L ☐R
☐	Breast MRI	
☐	Cyst Aspiration	☐L ☐R
☐	Needle/Wire Placement ☐US ☐Mammo ☐MRI	
☐	Stereotactic Biopsy	☐L ☐R
☐	MRI Guided Biopsy	☐L ☐R
☐	Ultrasound Guided Biopsy	☐L ☐R
☐	Bone Density	

X-Ray Views ☐ 1 ☐ 2 ☐ 3 Side ☐ L ☐ R

☐ Chest ☐ Ribs ☐ Clavicle ☐ Shoulder
☐ l-Spine ☐ T-Spine ☐ C-Spine ☐ Toe ☐ Heel
☐ Foot ☐ Wrist ☐ Fore Arm ☐ Hand ☐ Elbow
☐ Pelvis ☐ Hip ☐ Sacroiliac Joint
☐ Hip ☐ Abdomen
☐ Tib-Fib ☐ Ankle ☐ Knee ☐ Femur ☐ Humerus

Other Requests:

Licensed Provider Signature _____ Date _____