



RADIOLOGY ORDER FORM

TO SCHEDULE: (512) 851-1011 | FAX order form to: (512) 857-7480

PATIENT'S LEGAL NAME	DATE OF BIRTH	PATIENT PHONE
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PATIENTS SIGNS/SYMPTOMS

PHYSICIAN NAME (please print) _____ ORDERING PHYSICIAN'S SIGNATURE _____ DATE/TIME _____	CALL REPORT TO: _____ FAX REPORT TO: _____ AFTER HOURS PHONE #: _____ SPECIAL INSTRUCTIONS _____
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DIAGNOSTIC			
X-RAY	LOWER EXTREMITIES		CT Angio Coronary
CRANIAL	Ankle (2-view) <input type="checkbox"/> R <input type="checkbox"/> L		CT Angio Head
Facial Bones	Ankle Complete <input type="checkbox"/> R <input type="checkbox"/> L		CT Angio Neck
Mandible	Femur <input type="checkbox"/> R <input type="checkbox"/> L		CT Angio Pelvis
Nasal Bones	Foot <input type="checkbox"/> R <input type="checkbox"/> L		ULTRASOUND
Sinuses	Hip <input type="checkbox"/> B/L <input type="checkbox"/> R <input type="checkbox"/> L		Abdomen Complete
Skull	Knee (2-view) <input type="checkbox"/> R <input type="checkbox"/> L		Abdomen Limited
Waters View	Knee Complete <input type="checkbox"/> R <input type="checkbox"/> L		Abdomen Doppler
THORAX	Calcaneous <input type="checkbox"/> R <input type="checkbox"/> L		Appendix
Chest (1-view)	Pelvis A/P		Aorta Doppler
Chest (2-view)	Tibia/Fibula <input type="checkbox"/> R <input type="checkbox"/> L		Urinary Bladder
Ribs <input type="checkbox"/> B/L <input type="checkbox"/> R <input type="checkbox"/> L	Toe(s) <input type="checkbox"/> R <input type="checkbox"/> L		Biophysical Profile
SPINE	CT		Breast Bilateral
C-Spine (2-view)	Abdomen/Pelvis w/ Contrast <input type="checkbox"/> R <input type="checkbox"/> L		Breast Unilateral <input type="checkbox"/> R <input type="checkbox"/> L
C-Spine (3-view)	Abdomen/Pelvis w/o Contrast		Carotid Doppler
C-Spine Flex/Ext Only	Abdomen w/o Contrast		Chest
C-Spine Complete w/ F/E	C-Spine		Gall Bladder
C-Spine Complete	Chest w/ Contrast		Lower Extremity Arterial Doppler Unilateral <input type="checkbox"/> R <input type="checkbox"/> L
T-Spine (3-view)	Chest w/o Contrast		
L-Spine (2-view)	Coronary Calcium Score		Lower Extremity Arterial Doppler Bilateral with ABI
L-Spine Flex/Ext	Enterography		
L-Spine Complete w/ F/E	Head w/ & w/o Contrast		Lower Extremity Venous Doppler Unilateral <input type="checkbox"/> R <input type="checkbox"/> L
L-Spine Complete	Head w/o Contrast		
Scoliosis Survey	L-Spine		Lower Extremity Venous Doppler Bilateral
ABDOMEN	Lower Extremity w/o Contrast <input type="checkbox"/> R <input type="checkbox"/> L		Non-Vascular Extremity Limited
Abdomen/Kub	Mastoid (iacs) w/ Contrast		Obstetrical < 14 Weeks w/ Transvaginal
Abdomen (2-view)	Neck (soft tissue) w/ Contrast		Obstetrical > 14 Weeks w/ Transabdominal
Abdomen Series	Pelvis w/ Contrast		Pelvic Transvaginal w/ Doppler
Sitz Maker	Pelvis w/o Contrast		PVR Post Void Residual of Urinary Bladder
UPPER EXTREMITIES	Sinuses		Renal
Elbow <input type="checkbox"/> R <input type="checkbox"/> L	T-Spine		Scrotal Doppler
Finger(s) <input type="checkbox"/> R <input type="checkbox"/> L	Upper Extremity w/o Contrast <input type="checkbox"/> R <input type="checkbox"/> L		Thyroid/Soft Tissue Neck
Forearm <input type="checkbox"/> R <input type="checkbox"/> L	CT ANGIO		Upper Extremity Arterial Doppler Bilateral
Hand <input type="checkbox"/> R <input type="checkbox"/> L	CT Angio AAA		Upper Extremity Arterial Doppler Unilateral <input type="checkbox"/> R <input type="checkbox"/> L
Humerus <input type="checkbox"/> R <input type="checkbox"/> L	CT Angio Abdomen		
Shoulders <input type="checkbox"/> R <input type="checkbox"/> L	CT Angio Abdomen/Pelvis		Upper Extremity Venous Doppler Bilateral
Wrist (2-view) <input type="checkbox"/> R <input type="checkbox"/> L	CT Angio Abdomen w/ Runoff		Upper Extremity Venous Doppler Unilateral <input type="checkbox"/> R <input type="checkbox"/> L
Wrist Complete <input type="checkbox"/> R <input type="checkbox"/> L	CT Angio Chest		

