KAISER PERMANENTE®

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500 NE Multnomah St., Suite 100, Portland, OR 97232.

Radiology Order Form

Regional Imaging Services

Today's date: _____

PATIENT NAME: *(last, first)*		
HEALTH RECORD NO.:	**DOB:**	**GENDER:**
REASON FOR EXAM:		
PERTINENT MEDICAL INFO: *(e.g. patient weight, allergies, lab, LMP)*		
☐ IP Inpatient room No.: _____	☐ OP ☐ ED	ER Room No.: _____

PROVIDER NPI (UPIN):		
ORDERING/REFERRING CLINICIAN: *(please print)*		
OFFICE PHONE/FAX:	**CC:**	
SIGN OR SYMPTOM/DIAGNOSIS: *(Please note: sign or symptom necessitating the reason for the visit must be provided before rendering the service…Do not include a 'rule-out' diagnosis). When ordering multiple tests on the same order form, please indicate a sign or symptom for each test/treatment.*		
ICD-10 CODE:		

GENERAL RADIOLOGY														
	Skull							Chest	1 view			2 view		
	Orbits							Ribs		R		L		B
	Orbits for MRI							Cervical spine						
	SINUS							Thoracic spine						
	Facial bones							Lumbar spine						
	Clavicle			R	L	B		Soft tissue neck						
	Shoulder	2 view	3 view	R	L	B		Scoliosis						
	Humerus			R	L	B		Pelvis						
	*Elbow			R	L	B		Femur						
	*Forearm			R	L	B		Hip (Ap & Lat)			R	L	B	
	*Wrist	2 view	3 view	R	L	B		Knee	2 view	3 view	R	L	B	
	*Hand	2 view	3 view	R	L	B		Tibia/Fibia						
	*Finger	Digit:		R	L	B		*Ankle	2 view	3 view	R	L	B	
	Bone Density Exam (DEXA Scan)							*Foot	2 view	3 view	R	L	B	
	A. Primary Screening							*Toe	Digit:		R	L	B	
	B. Secondary Screening							Abdomen Acute series						
	C. Osteoporosis Management (follow up)							Abdomen (KUB)						
								EKG						

Other:
ORDERING CLINICIAN'S SIGNATURE: *(no stamps)*

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