KAISER PERMANENTE®

Today's date: _____

REGIONAL RADIOLOGY SERVICES
RADIOLOGY ORDER FORM

PLEASE NOTE THAT ALL HIGHLIGHTED PORTIONS OF THE FORM ARE NEEDED FOR THE ORDER TO BE COMPLETE

For Radiology Orders:

1. Mark requested study(ies)
2. Sign and date form
3. Fax request to: 303-861-3111
4. Patient must bring order form to any Radiology department (Monday through Friday 8:00 A.M 6:00 P.M)

PATIENT NAME (LAST, FIRST):					
HEALTH RECORD NO:		DOB:		GENDER:	
PHONE Hm:		Wk:		Cell:	
PERTINENT MEDICAL INFO (e.g. Patient weight, Allergies, Lab, LMP):					
PATIENT PREGNANT:	Y / N				
ORDERING/REFERRING CLINICIAN (Please print):					
PROVIDER NPI (UPIN):		OFFICE PHONE:		PAGER:	
EXAM:	Routine w/in 2 weeks	ASAP 1-2 days	STAT	Send CDs w/ patient: Y/N	
FAX RESULTS TO:		CC:			
SIGN OR SYMPTOM/DIAGNOSIS:	(Please Note: Sign Or Symptom Necessitating The Reason For The Visit Must Be Provided Before Rendering The Service):				
ICD-9 Code:					

RADIOLOGY PROCEDURES									
	CHEST	2 VIEW		1VIEW		ORBITS	4 VIEW	1VIEW (PRE-MRI)	
	DECUBITAL CHEST	R	L	Bil		SINUS			
	ABDOMEN					FACAIL BONES			
	SKELETAL SURVEY					CERVICAL SPINE	2 VIEW	3VIEW (ODONTOID)	
	RIBS	R	L	Bil		THORACIC SPINE			
	CLAVICLE	R	L	Bil		LUMBAR SPINE			
	SHOULDER	R	L	Bil		PELVIS			
	SCAPULA	R	L	Bil		HIP	R	L	Bil
	ELBOW	R	L	Bil		FEMUR	R	L	Bil
	FOREARM	R	L	Bil		KNEE	R	L	Bil
	WRIST	R	L	Bil		TIBIA / FIBULA	R	L	Bil
	HAND	R	L	Bil		ANKLE	R	L	Bil
	FINGER DIGIT_____	R	L	Bil		FOOT	R	L	Bil
	OTHER:					TOE DIGIT_____	R	L	Bil
						OTHER:			
	ORDERING CLINICIAN'S SIGNATURE **Required:** ➡					DATE:			