The Medical Center of Plano 3901 W. 15th Street Plano, TX 75075 Phone 972-612-6500 Fax 469-484-0512

☐ Main Campus: 3901 West 15th **ED Entrance** ☐ Building III: 4001 West 15th **Suite #160-A**

Please call, 972.612.6500 for appointment - Monday - Friday 8:00 am - 5:30 pm

☐ **Contact patient to schedule appointment.**
Patient Name: _____
Birth Date: _____ Gender: **M**☐ or **F**☐
SS # (optional): _____
Phone: _____ Alternate phone: _____

DX/Reason for testing: _____

☐ **Obtain precertification for procedure.**
Please, provide the following information, or fax ID/ Demo sheet.
Name of Insurance: _____
Phone: _____ ID #: _____ Group #: _____
Name of Insured: _____
The Medical Center of Plano Scheduling can obtain precert for High Tech Radiology Procedures, upon request.
(Please fax patient's clinical information with complete order.)

PLEASE ALLOW 30 MINUTES FOR REGISTRATION PROCESS. BRING THIS FORM, INSURANCE CARDS, PICTURE ID AND ANY PREVIOUS OUTSIDE EXAMS WITH YOU.

General Diagnostic

☐ Right ☐ Left

- ☐ Abdomen 2V AP and Lateral
- ☐ Abdomen Single AP (KUB)
- ☐ AC Joints Bilateral
- ☐ Ankle 2V
- ☐ Ankle Complete
- ☐ Bone Age Study
- ☐ Bone Survey: Skeletal Survey
- ☐ Calcaneus (Heel)
- ☐ Chest IV ☐ *AP* ☐ *PA*
- ☐ Chest 2V; PA and Lateral
- ☐ Chest 2V with Obliques
- ☐ Chest PA; Insp. & Exp.
- ☐ Chest Apical Lordotic Only
- ☐ Chest Lateral Decubitus Only
- ☐ Clavical AP & Lateral
- ☐ Cervical Spine 2V with Odontoid
- ☐ Cervical Spine Complete
- ☐ Elbow ☐ 2V ☐ 3V
- ☐ Facial Bones Complete
- ☐ Femur AP and Lateral
- ☐ Finger (s) 3V _____
  ☐ *Specify:* _____
- ☐ Foot ☐ 2V ☐ 3V
- ☐ Forearm 2v
- ☐ Hand ☐ 2V ☐ 3V
- ☐ Hip 1V
- ☐ Hip Complete
- ☐ Humerus
- ☐ Infant Ext. 2V ☐ Lower ☐ Upper
- ☐ Knee 2V
- ☐ Knee Complete
- ☐ Lumbar Spine AP & Lateral
- ☐ Lumbar Spine Complete
- ☐ L-Spine Complete w/bending
- ☐ Mandible Complete 5V
- ☐ Nasal Bones
- ☐ Pelvis AP Only
- ☐ Pelvis Complete
- ☐ Pelvis & Hips: Infant / Child
- ☐ Ribs
- ☐ Sacroiliac Joints
- ☐ Sacrum and Coccyx
- ☐ Scapula
- ☐ Shoulder 3V
- ☐ Shoulder AP only
- ☐ Sinuses less than 3V
- ☐ Sinuses Complete
- ☐ Skull ☐ 2V ☐ 4V
- ☐ Soft Tissue Neck
- ☐ Sternoclavicular Joints
- ☐ Sternum
- ☐ Tib/Fib 2V
- ☐ Thoracic Spine
- ☐ TMJ Open and Closed Mouth
- ☐ Toe (s) 3V: _____
- ☐ Wrist ☐ 2V ☐ 3V
- ☐ Other: _____

Fluoroscopic Procedures

- ☐ Arthrogram: _____
- ☐ Colon Barium Enema
- ☐ Colon BE Air Contrast
- ☐ Colon - Hypaque
- ☐ Contrast Enema - Intussuseption
- ☐ Cystogram
- ☐ Esophagus / Barium Swallow
- ☐ Esophagus / Barium Tablet Swallow
- ☐ Fistulagram
  ☐ *Specify:* _____
- ☐ Hysterosalpingogram
- ☐ Lumbar Puncture / Blood Patch
- ☐ Modified Barium Swallow
- ☐ Retrograde Urethrogram
- ☐ Small Bowel Series (SBS)
- ☐ Sialogram
- ☐ SNIFF Test
- ☐ Upper GI Series (UGI)
- ☐ Upper GI Series Gastrografin
- ☐ Venogram Lower Extremity
  ☐ Right ☐ Left
- ☐ Voiding Cystogram
- ☐ Other: _____

Nuclear Medicine

- ☐ Bone Scan: ☐ Limited ☐ Whole Body
- ☐ 3 Phase ☐ SPECT
  ☐ *Specify:* _____
- ☐ Cardiac Muga Scan
- ☐ Cisternogram
- ☐ Gallium Scan
- ☐ Gastric Emptying Study
- ☐ Hepatobiliary Scan (HIDA)
  ☐ With CCK ☐ Without CCK
- ☐ I131 Thyroid Ablation (Cancer)
  ☐ with Follow - up Scan
  ☐ Specify Dosage: _____
- ☐ I131 Thyroid Ablation (Hyperthyroidism)

- ☐ I111 Indium Tagged WBC Scan
- ☐ I111 Octreotide / Pentreotide
- ☐ Liver / Spleen Scan
- ☐ Lung Scan (VQ Scan)
- ☐ Lymphoscintigraphy
- ☐ Parathyroid Scan (Sestimibi)
- ☐ RBC Tag (GI Bleed)
- ☐ Renal Scan - DMSA
- ☐ Renogram Flow and Imaging
- ☐ Renogram with Captopril
- ☐ Thyroid Imaging (Nodule)
- ☐ Thyroid Uptake and Scan
- ☐ Voiding Cystogram (Nuc Medicine)

MRI

☐ With Gado ☐ Without Gado
☐ With and Without Gado

- ☐ Aorta with Runoff
- ☐ Abdomen
- ☐ Abdomen Angiography
- ☐ Brachial Plexus
- ☐ Breast
- ☐ Cardiac
- ☐ Carotid Angiography
- ☐ Chest
- ☐ Chest Angiography
- ☐ Cholangiogram
- ☐ Extremity: ☐ Upper ☐ Lower ☐ Right ☐ Left
- ☐ Face
- ☐ Head / Brain
- ☐ Head / Brain Angiography
- ☐ Hip: ☐ Right ☐ Left
- ☐ Internal Auditory Canal (IAC)
- ☐ Joint: Specify: _____ ☐ Right ☐ LefT
- ☐ Neck - Soft Tissue
- ☐ Orbits
- ☐ Pelvis
- ☐ Pelvis Angiography
- ☐ Sacrum
- ☐ Shoulder without Arthrogram
- ☐ Shoulder with Arthrogram
- ☐ Spine - Cervical
- ☐ Spine - Lumbar
- ☐ Spine - Thoracic
- ☐ Tempormandibular Joint (TMJ)
- ☐ Venogram: Specify: _____
- ☐ Other: _____

PET Imaging

- ☐ PET Imaging Whole Body (Cancer)
- ☐ Specify Type of Cancer: _____
- ☐ Exam Indication: ☐ Initial Diagnosis
- ☐ Clinical Staging ☐ Restaging

- ☐ PET Imaging BRAIN
- ☐ Specify Type of Cancer: _____
- ☐ Exam Indication: ☐ Initial Diagnosis
- ☐ Clinical Staging ☐ Restaging

Tomography

- ☐ IVP with Tomos
- ☐ IVP without Tomos
- ☐ Single Plane Tomography

CT Angiogram

☐ Specify Area: _____

☐ With Contrast
☐ With and Without Contrast

Ultrasound

- ☐ Abdomen Complete
- ☐ Abdomen for Aorta
- ☐ Carotid Duplex Bilateral
- ☐ Chest to Include Mediastinum
- ☐ Duplex Abdomen Complete
- ☐ Duplex Extremity Soft Tissue ☐ Upper ☐ Lower ☐ RT. ☐ LT.
- ☐ Duplex Extremity Venous ☐ Upper ☐ Lower ☐ RT. ☐ LT.
- ☐ Hysterosonography
- ☐ Infant Hip W/O manipulation
- ☐ Infant Hip with Manipulation
- ☐ Neck Soft Tissue (Mass)
- ☐ Neonatal Neuro Head
- ☐ Paracentisis
- ☐ Pelvic / Transvaginal
- ☐ Pregnancy 1st Trimester
- ☐ Pregnancy 2nd & 3rd Trimester
- ☐ Retropeiritoneal (Renal)
- ☐ Segmental Pressures (Arterial) ☐ Upper ☐ Lower
- ☐ Spine
- ☐ Temporal Arteries
- ☐ Testicular
- ☐ Thoracentesis
- ☐ Thyroid
- ☐ Venous Mapping
  ☐ *Specify:* _____

☐ **DEXA Bone Density Scan**

CT Scan

☐ With Contrast ☐ Without Contrast
☐ With and Without Contrast

- ☐ Abdomen
- ☐ Chest / Thorax
- ☐ Extremity ☐ Upper ☐ Lower ☐ Right ☐ Left
- ☐ Facial Bones
- ☐ Head / Brain
- ☐ Internal Auditory Canal (IAC)
- ☐ Maxillofacial w/o coronals
- ☐ Neck - Soft Tissue
- ☐ Orbits
- ☐ Pelvis
- ☐ Renal Arteries
- ☐ Retropeiritonemn
- ☐ Sinuses ☐ Limited ☐ Complete
- ☐ Sella Turcicia
- ☐ Spine - Cervical
- ☐ Spine - Lumbar
- ☐ Spine - Thoracic
- ☐ Temporal Bones
- ☐ Tempormandibular Joint (TMJ)
- ☐ Urogram
- ☐ Other: _____

Any patient 65 or older; Diabetes; Hypertension; Renal Disease; or Multiple Myeloma must have BUN and Creatine within 30 days prior to any contrast media study:

☐ **BUN: _____ CREATININE: _____ DATE: _____** (or fax copy of lab with this order)

☒ **Draw BUN & Creatinine if no prior results and Patient meets above criteria**

☐ **Call Report STAT** ☐ **Phone Results** ☐ **Fax Results** ☐ **Hold Patient for Instructions** ☐ **Send Films w/Pt** ☐ **Send CD w/Pt**

Physician's Signature: _____ Printed Name: _____ Date: _____ Time: _____

The Medical Center *of* Plano

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RADIOLOGY OUTPATIENT TEST ORDERS

* P O S *

OTO-003 (Rev 05/13) Mac 7002

PATIENT IDENTIFICATION