

## McLaren Print System Order

Order No: 44854  
 Order Date: 2019-04-24  
 User: Jodi Peterman  
 Phone: 3422133

Ship Location: Jodi Peterman - McLaren Flint MRI Ballenger  
 750 S Ballenger Hwy  
 Flint, MI 48532

Forms  
 Quantity: 25  
 Paragon Dept No: 32113  
 Dept Name: McLaren Flint MRI Ballenger  
 Company Number: 60

Order Total Price: 327.50

Item Number: M-22016-B  
 Item Description: Imaging Center Order Form  
 Revision Date: 5/2018  
 Print:  
 Paper:  
 Size:  
 Fold:  
 Finish:  
 Drill:  
 Misc Info: ds; full color; 50 Sheets per pad. Please order how many pads you would like. BW

McLaren FLINT		OUTPATIENT RADIOLOGY ORDER FORM		Appointment Date _____	Appointment Time _____	
(OPTIONAL) WEST 75000 McLaren Imaging Center • Ph: 810.342.4800 Fax: 810.342.4808 McLaren MRI Ballenger Hwy • Ph: 810.226.8010 Fax: 810.226.8018						
Patient Name _____ DOB _____ Height _____ Weight _____						
INSTITUTION PHONE _____						
INSURANCE _____ PMS AUTHORIZATION NUMBER _____						
DIAGNOSIS/REASON FOR EXAM (PLEASE INCLUDE LATERALITY, SPECIFIC SITE)						
ORDERING PROVIDER (PRINT NAME) _____		OFFICE CONTACT _____				
MRI	<input type="checkbox"/> GREY <input type="checkbox"/> AXIAL <input type="checkbox"/> SAGITT	<input type="checkbox"/> INITIAL STAGING <input type="checkbox"/> BRILL TO WHO FRIGID <input type="checkbox"/> ANGIOGRAPHIC VIABILITY <input type="checkbox"/> BMT BONE SCANS	<input type="checkbox"/> SUBSEQUENT <input type="checkbox"/> BRILL TO WHO (MELANOMA) <input type="checkbox"/> BRAIN ANGIOGRAPHIC VIABILITY <input type="checkbox"/> GALLBLADDER CALCULI			
	<input type="checkbox"/> FLUOROSCOPY <input type="checkbox"/> SINGLE SWALLOW <input type="checkbox"/> NEED ESCAN GENERAL X-RAY NO APPOINTMENT NEEDED		<input type="checkbox"/> LD <input type="checkbox"/> RP <input type="checkbox"/> VQAS <input type="checkbox"/> CHESTGRAM	<input type="checkbox"/> SE <input type="checkbox"/> BE <input type="checkbox"/> CHYSTOGRAM - See Back of Order for Page		
US	<input type="checkbox"/> PELVIC (WITH TRANS VAG IF NECESSARY) <input type="checkbox"/> ABDOMEN <input type="checkbox"/> PROSTATE <input type="checkbox"/> COLOR DOPPLER	<input type="checkbox"/> TESTICLES (WITH COLOR FLOW IF NECESSARY) <input type="checkbox"/> BLADDER <input type="checkbox"/> THYROID <input type="checkbox"/> CAROTIDS <input type="checkbox"/> OTHER	<input type="checkbox"/> RENAL/KIDNEY <input type="checkbox"/> BREAST FOUNDATION <input type="checkbox"/> BREAST <input type="checkbox"/> ARTERIAL <input type="checkbox"/> COLORFLOW IF NECESSARY <input type="checkbox"/> OTHER			
	<input type="checkbox"/> ESO <input type="checkbox"/> LESS THAN 10 WKS <input type="checkbox"/> MORE THAN 10 WKS <input type="checkbox"/> LIMITED <input type="checkbox"/> SONOGRAPHIC					
CT	<input type="checkbox"/> HEAD <input type="checkbox"/> SOFT TISSUE NECK <input type="checkbox"/> SPINE <input type="checkbox"/> OTHER	<input type="checkbox"/> CHEST <input type="checkbox"/> HIGH-RES CHEST <input type="checkbox"/> ABDOMEN <input type="checkbox"/> UROGRAM	<input type="checkbox"/> PELVIS <input type="checkbox"/> SPINE <input type="checkbox"/> RENAL STONE <input type="checkbox"/> L-SPINE <input type="checkbox"/> OTHER	<input type="checkbox"/> CTR <input type="checkbox"/> NORTH <input type="checkbox"/> ROOMEN <input type="checkbox"/> ROOMEN/PELVIS <input type="checkbox"/> CONFIRMED <input type="checkbox"/> EXTREMITY <input type="checkbox"/> NORTH BRANCH <input type="checkbox"/> OTHER	- See Back of Order for Page	
	<input type="checkbox"/> 3 PHASE BONE <input type="checkbox"/> TOTAL BONE BODY (WITH 3 PHASE IF NECESSARY) <input type="checkbox"/> VIB SCAN <input type="checkbox"/> HIDA SCAN		<input type="checkbox"/> WITH TOTAL BODY IF NECESSARY <input type="checkbox"/> WITH ULTRASOUND IF NEEDED <input type="checkbox"/> BILATERAL <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT			
MISC	<input type="checkbox"/> MAMMOGRAPHY (state no description or problem being previous mammogram) <input type="checkbox"/> A/D SCREENING <input type="checkbox"/> B/D SCREENING					
	<input type="checkbox"/> WITH ULTRASOUND IF NEEDED <input type="checkbox"/> BILATERAL <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT					
MISC	<input type="checkbox"/> LUMP PAIR THICKENING <input type="checkbox"/> NIPPLE D/C <input type="checkbox"/> ABNORMAL MAMM <input type="checkbox"/> OTHER					
	<input type="checkbox"/> BONE DENSITOMETRY <input type="checkbox"/> L.S. SPINE/HP					
<input type="checkbox"/> TELEPHONE REPORT (Please Patient) _____ <input type="checkbox"/> TELEPHONE REPORT (Please Patient) _____		PROVIDER Signature _____ Date _____ Time _____ Signature Errors are NOT valid				
Contract with order is necessary to optimize the diagnostic capability of the exam. Additional studies will be performed as clinically necessary to optimize the diagnostic capability of the study that is being performed (e.g., a hip for an abnormal bone scan). Signing this form indicates your agreement of the above.						

Spec Info:

