Salt Lake Regional
MEDICAL CENTER

1050 East South Temple. Salt Lake City, Utah 84102

Fill in all outlined fields before printing.

IMAGING SERVICES OUTPATIENT PHYSICIAN ORDERING FORM

Print Form

Centralized Scheduling: phone: 801.350.4451 fax: 801.350.4303 Radiology Front Desk: 801.350.8296

☐ **URGENT (1 day)** ☐ **ASAP (1 - 3 Days)** ☐ **ROUTINE** ☐ **Patient will call to schedule**

DATE:	PATIENT NAME: (please print)		
DAYTIME PHONE:	EVENING PHONE:	OTHER PHONE:	
DOB:	SOCIAL SECURITY#:	SEX:	
INSURED NAME:	INSURED SSN#	INSURED ID#:	
INSURANCE CARRIER #1:	INSURANCE CARRIER #2:	PRE-AUTH #:	
ORDERING PHYSICIAN: (please print)		PHYSICIAN PHONE #	
DIAGNOSIS:			
PHYSICIAN SIGNATURE:		DATE:	

MRI: _____

☐ Metal or Implanted Devices _____ ☐ PT < 350 lbs

☐ Radiologist to determine need for contrast ☐ Without Contrast ☐ With & Without Contrast*

** For Contrast Exam Creatinine within 6 weeks if PT is 60 or older, diabetic, Hx Kidney dz, transplant or single kidney, uncontrolled hypertension, Hx liver dz or transplant. * Contrast Allergy needs premedication*

MRA: _____

CT: _____

☐ Radiologist to determine need for IV Contrast ☐ Include Patient Medication List for Contrast Studies

☐ With & Without IV Contrast (if needed)* ☐ With IV Contrast* ☐ Without IV Contrast

☐ IV With Oral Contrast

* *Contrast Studies need Bun & Creatinine within 30 days if PT is 65 or older, Diabetic, Hx Kidney dz, transplant or single kidney, uncontrolled hypertension. * Contrast Allergy needs premedication*

X-RAY _____ **FLUORO/IVPS:** _____

NUC MED _____

☐ Myocardial Perfusion Rest/Stress (using one of the following two options):

☐ Treadmill ☐ Adenosine Stress (*Please state reason*) _____

☐ MUGA w/ejection fraction

☐ **RUQ Pain Evaluation:** *Abd ultrasound, HIDA scan to follow if ultrasound negative*

ULTRASOUND: ☐ Abdominal Limited (*NPO 6-8 hrs*) ☐ Abdominal Complete (*NPO 6-8 hrs*)

☐ Pelvic w/Transvaginal *(full bladder needed)* ☐ Pelvic *(full bladder needed)*

☐ Obstetrical ☐ Breast ☐ Scrotum ☐ Renal/Bladder *(full bladder needed)*

☐ Thyroid ☐ Carotid ☐ Other_____

☐ Extremity Doppler ☐ UPPER ☐ LOWER ☐ RIGHT ☐ LEFT ☐ BILATERAL

MAMMO: (*prior films required*): ☐ Diagnostic ☐ Stereotactic / RT / LT _____#Sites

☐ **BONE DENSITY SCAN:** _____