THIS ORDER MUST BE PRESENTED AT THE TIME OF SERVICE

Lifespan Medical Imaging
Rhode Island Hospital · The Miriam Hospital
Newport Hospital
Delivering health with care®

Please select if you have a location preference:

- ☐ The Miriam Hospital
- ☐ 195 Collyer St
- ☐ 900 Warren Ave (Coastal Building)
- ☐ 375 Wampanoag Trail
- ☐ 146 West River Street
- ☐ Rhode Island Hospital
- ☐ Medical Office Center Building (MOC)
- ☐ Newport Hospital
- ☐ Portsmouth Imaging Center

Please contact patient to make appointment ☐ Yes ☐ No

☐ STAT ☐ ROUTINE EXPECTED DOS:_____

First Name: _____ Last Name: _____

DOB:_____ Phone: _____ Insurance Plan /Plan #:: _____

Patient's Address: _____ City/State: _____ Zip Code: _____

Clinical Decision Support G Code: _____ Clinical Decision Support Modifier: _____

ICD 10 Codes (REQUIRED):_____

Signs/Symptoms /Reasons for Exam (REQUIRED): _____

Ordering Provider (printed): _____ Office Phone: _____

Provider Signature: ** _____ Date: _____

****MUST BE ORIGINAL SIGNATURE ; STAMPED SIGNATURES NOT ACCEPTED**

CT SCAN

CONTRAST
☐ IV Contrast ☐ No IV Contrast
☐ Oral Contrast ☐ Per Radiologist

CT BRAIN / HEAD
☐ Brain ☐ Temporal Bone
☐ Mastoid ☐ Brain Venogram
☐ Gamma Knife
☐ Brain CTA

CT FACE
☐ Sinus ☐ Orbits
☐ Face

CT NECK
☐ Neck ☐ Neck CTA

CT CHEST
☐ Chest
☐ High Resolution Chest
☐ Lung Cancer Screening
☐ Pulmonary embolus
☐ Aortic Dissection
☐ Chest CTA

CT SPINE
☐ Cervical Spine
☐ Thoracic Spine
☐ Lumbar Spine
☐ Post Myelogram _____ spine

SPECIALTY EXAMS
☐ CT Virtual Colonoscopy
☐ CT Enterography
☐ Calcium Scoring
☐ Pulmonary Vein Map
☐ CTA Coronary

CT ABDOMEN & PELVIS
☐ Abdomen & Pelvis
☐ Abdomen Pelvis Venogram
☐ Renal/Ureter Stone
☐ Hematuria
☐ CTA Endoleak

CT ABDOMEN
☐ Abdomen ONLY (no pelvis)
☐ Liver ☐ Adrenal
☐ Pancreas ☐ Kidney
☐ Renal CTA
☐ Abdomen CTA

CT PELVIS
☐ Pelvis ONLY (no abdomen)
☐ Pelvis CTA

CT EXTREMITIES ☐ RIGHT ☐ LEFT
☐ Wrist
☐ Elbow
☐ Shoulder
☐ Hips
☐ Femur
☐ Knee
☐ Tibia/Fibula
☐ Ankle
☐ Foot /Calcaneous
☐ _____ Arthrogram: _____
☐ Lower Extremity "Run-Off" CTA
Levels: _____
☐ Upper Extremity CTA
☐ Upper Extremity Venogram
☐ **Other**_____

MRI

MRI CONTRAST ☐ With & Without ☐ Without

NEURO
☐ Brain: _____
Region of interest: _____
☐ Spectroscopy
☐ Functional Brain
☐ Soft Tissue Neck: _____
☐ **MR Angiography Head**
☐ Venous Flow
☐ Arterial Flow
☐ **MRA Neck:**
☐ Dissection
☐ Atherosclerosis

MR MUSCULOSKELETAL
SIDE: ☐ RIGHT ☐ LEFT
☐ Shoulder ☐ Hip
☐ Humerus ☐ Thigh
☐ Elbow ☐ Knee
☐ Forearm ☐ Lower Leg
☐ Wrist ☐ Ankle
☐ Hand ☐ Foot
☐ _____ Fingers
☐ _____ Toes
☐ Arthrogram _____
Specify joint: _____

MRI BODY
☐ Chest ☐ Adrenals
☐ Liver: _____ ☐ Kidneys
☐ MRCP/Pancreas
☐ Abdomen: _____
☐ Elastography
☐ Fetal
☐ Pelvis: _____
☐ MR Enterography ***(Abdomen+Pelvis Study)***

MRA BODY
☐ **MRA Chest:** _____
☐ **MRA Abdomen:** _____
☐ **MRA Pelvis:** _____
☐ **MRA Extremity** ***Please specify:*** _____

MR SPINE
☐ Cervical
☐ Thoracic
☐ Lumbar
☐ Entire Spine *(C, T, & L spine)*
☐ Brachial Plexus *(MRI Chest study)*
☐ RIGHT ☐ LEFT

MRA Spine: _____

****MRI CARDIAC-Use detailed form***
****MRI BREAST- Use detailed form***

Will patient require anesthesia or pediatric sedation? If yes, please fill out sedation form.
If patient has any of the following conditions, the patient may need a creatinine level drawn within 6 weeks of appointment. Please fax creatinine to 444-5732 if acquired outside Lifespan Laboratories.

☐**YES** ☐**NO** **Renal Disease or transplant**
☐**YES** ☐**NO** **Dialysis**

If patient has an implanted electronic device (Pacemaker/ICD/Neurostimulator) please contact the MRI department at 444-4881.
If patient is pregnant and within 1st trimester, please contact the MRI department and speak to an attending radiologist 444-4881.
***To request MRI Cardiac or MRI Breast forms please contact imaging@lifespan.org with your request.**

THIS PHYSICIAN ORDER MUST BE PRESENTED AT THE TIME OF SERVICE

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Please contact patient to make appointment ☐ Yes ☐ No

☐ STAT ☐ ROUTINE EXPECTED DOS:_____

First Name: _____ Last Name: _____

DOB:_____ Phone: _____ Insurance Plan /Plan #:: _____

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ICD 10 Codes (REQUIRED):_____

Signs/Symptoms /Reasons for Exam (REQUIRED): _____

Ordering Provider (printed): _____ Office Phone: _____

Physician Signature: ** _____ Date: _____

****MUST BE ORIGINAL SIGNATURE ; STAMPED SIGNATURES NOT ACCEPTED**

ULTRASOUND

ABDOMEN

- ☐ Abdomen Complete (with vascular evaluation if needed)
- ☐ Abdomen w/ Contrast
- ☐ Right Upper Quadrant Limited (with vascular evaluation if needed)
- ☐ CCK GB ejection fraction (RIH MOC ONLY)
- ☐ Renal with bladder (Post Void Residual)
- ☐ Renal with blood flow (resistive index) Doppler
- ☐ Renal - no vascular evaluation
- ☐ Renal-Complete Doppler- RAS
- ☐ Renal Transplant with Doppler evaluation
- ☐ Abdominal Aorta Follow up ☐ Abdominal Aorta Screening
- ☐ Liver with Doppler and Elastography
- ☐ Chest

SMALL PARTS

- ☐ Thyroid/Parathyroid
- ☐ Palpable Lump (designated area to be evaluated)_____
- ☐ Thyroid Biopsy **Location**_____**/or ☐Determined by Radiologist**

OTHER (please specify)

- ☐ Non-Vascular Extremity Other_____
- ☐ Groin/Hernia _____
- ☐ Palpable Lump (designated area to be evaluated)_____
- ☐ MSK (please specify)_____
- ☐ ABI ***For ABI's to be scheduled at RIH call 444-5194***

MALE PELVIS

- ☐ Testes (with blood flow Doppler evaluation if needed)
- ☐ Pelvis ☐ Pelvis– Post Void Residual only
- ☐ Prostate ☐ Prostate Bx

FEMALE PELVIS

- ☐ Transabdominal (with Transvaginal and/or Doppler eval. if needed)
- ☐ Transvaginal (with Doppler evaluation if needed)
- ☐ OB (less than 14 weeks) LMP _____
- ☐ OB (greater than 14 weeks) EDD_____
- ☐ OB limited _____
- ☐ OB other_____
- ☐ Pelvis for Post Void Residual only

VASCULAR-VENOUS

- ☐ Lower Extremity ☐ RIGHT ☐ LEFT ☐ BILATERAL
- ☐ Upper Extremity ☐ RIGHT ☐ LEFT ☐ BILATERAL

VASCULAR-ARTERIAL

- ☐ Carotid
- ☐ Temporal Arteries
- ☐ Lower Extremity Arterial ☐ RIGHT ☐ LEFT ☐ BILATERAL

CEREBROVASCULAR

- ☐ Transcranial Doppler Complete
- ☐ Transcranial Doppler Emboli WO Microbubble Injection
- ☐ Transcranial Doppler Emboli W Microbubble Injection

RADIOLOGY

GENERAL RADIOLOGY

EXTREMITY ☐ RIGHT ☐ LEFT

- ☐ Hand
- ☐ Wrist
- ☐ Forearm
- ☐ Elbow
- ☐ Humerus
- ☐ Shoulder
- ☐ Clavicle
- ☐ Scapula
- ☐ Finger (Specify)_____
- ☐ Pelvis
- ☐ Hip
- ☐ Femur
- ☐ Knee
- ☐ Tibia/Fibula
- ☐ Ankle
- ☐ Foot
- ☐ Toe (Specify) _____

☐ **BONE DENSITY DEXA HT:**_____**WT:**_____

ORDER COMMENTS: _____

_____

_____

- ☐ Chest specify:_____
- ☐ Ribs ☐ RIGHT ☐ LEFT
- ☐ Foreign Body
- ☐ Abdomen
  - ☐ Flat & Upright
  - ☐ Kidney/Ureters/Bladder(KUB)
- ☐ Spine
  - ☐ Cervical
  - ☐ Lumbar
  - ☐ Thoracic
  - ☐ Thoracolumbar
  - ☐ Scoliosis
- ☐ Sinus
- ☐ Bone Survey
- ☐ Metastatic Bone Series
- ☐ Scanogram
- ☐ Shunt Series

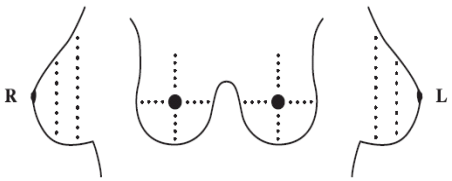
GI/FLUORO STUDIES

- ☐ Barium Enema
  - ☐with air ☐without air
- ☐ Barium Swallow
- ☐ Modified Barium Swallow w/Speech Pathology
- ☐ Pouch-o-gram
- ☐ Small Bowel
- ☐ Upper GI
- ☐ Defecogram
- ☐ Fistulogram

GU STUDIES

- ☐ VCUG
- ☐ Retrograde urethrogram
- ☐ Urethrogram
- ☐ Cystogram
- ☐ Loopogram
- ☐ Other: _____

BREAST IMAGING



Date of last exam:_____

- ☐ Screening Mammography
- ☐ Dense Breast Screening Ultrasound
- ☐ Mammography Diagnostic Bilateral/PRN Ultrasound
- ☐ Mammography Diagnostic Unilateral/PRN Ultrasound ☐ RIGHT ☐LEFT
- ☐ Breast Ultrasound ☐ RIGHT ☐ LEFT ☐ BILATERAL
  Location: _____

☐ RIGHT ☐ LEFT

- ☐ Ultrasound Guided Biopsy
- ☐ Cyst Aspiration
- ☐ Fine Needle Aspiration
- ☐ Stereotactic Biopsy
- ☐ Consultation w/imaging or biopsy prn

To request MRI Breast forms please contact imaging@lifespan.org with your request.