X-Ray / CT / US / Procedures

Kootenai Outpatient Imaging

PATIENT INFORMATION

Patient Name:_____ DOB:_____

Phone#:_____

Parent name (if patient is a minor):_____

Please specify ICD-10 and narrative diagnosis:
(Do not use unspecified, rule out, probable, possible, suspected or routine)

REFERRING PROVIDER

Date:_____

Ordering Provider (PRINT):_____

Ordering Providers Signature:_____

CC Provider: _____

Phone: _____

☐ STAT: Immediate Fax_____

Provider number to contact for critical results:

_____

Please add any additional pertinent information/ details below for radiologist and technologist.

_____

_____

X-Ray (Non-Scheduled Studies)

- ☐ Abdomen KUB (1v.)
- ☐ Abdomen Flat and Upright (2v.)
- ☐ Abdomen Acute series (3v.)
- ☐ Ankle: R / L
- ☐ Bone Survey (Scheduled)
- ☐ Chest (2v.)
- ☐ Elbow : R / L
- ☐ Femur: R / L
- ☐ Foot: R / L
- ☐ Forearm: R / L
- ☐ Hand: R / L
- ☐ Hip(s) + Pelvis: R / L
- ☐ Knee: R / L
- ☐ Leg Length
- ☐ Pelvis
- ☐ Ribs R / L
- ☐ Scoliosis Study
- ☐ Shoulder: R / L
- ☐ Spine Cervical
- ☐ Spine Thoracic
- ☐ Spine Lumbar
- ☐ Tibia & Fibula: R / L
- ☐ Wrist: R / L
- ☐ Other: _____

CT

☐ With IV Contrast ☐ Without IV Contrast ☐ With Oral Barium Contrast ☐ Without oral Barium Contrast ☐ Radiologist Discretion

Chest / ABD / Pelvis

- ☐ Chest
- ☐ Chest High Resolution
- ☐ Chest Lung Screening (w/o IV contrast)
- ☐ Abdomen (Diaphragm to Crest)
- ☐ Abdomen / Pelvis
- ☐ Abdomen / Pelvis (KUB)
- ☐ Abdomen Triple Phase (Abd w & w/o)
- ☐ Abdomen Triple Phase w/ Pelvis (Abd w & w/o & Pelvis with)
- ☐ IVP Urogram (Abd / pelvis w & w/o)
- ☐ Pelvis (Crest to Perineum)
- ☐ Pelvis without (Boney Pelvis)

Angio

- ☐ Angio Abdomen
- ☐ Angio Abdomen / Pelvis
- ☐ Angio Aortic Graft Protocol
- ☐ Angio Chest
- ☐ Angio Chest Gated
- ☐ Pulmonary Vein
- ☐ Angio Head
- ☐ Angio Head / Neck
- ☐ Angio Neck (w/ IV contrast)
- ☐ Angio Pelvis
- ☐ Angio Pulmonary (r/o PE)
- ☐ Angio Run-off

Head / Neck

- ☐ Facial Bones
- ☐ Head
- ☐ Orbital
- ☐ Parathyroid with and without
- ☐ contrast
- ☐ Pediatric Skull w/ 3D Recon (Head w/o contrast)
- ☐ Sinus
- ☐ Soft Tissue Neck
- ☐ Temporal / Mastoid / Ear
- ☐ Limited _____ (follow up)
- ☐ Other _____

Spine

- ☐ C-Spine
- ☐ T-Spine
- ☐ L-Spine
- ☐ Globus Spine - Specify Level: (w/o contrast)

_____

Extremities

- ☐ Extremity: R / L
- ☐ Hip: R / L
- ☐ Shoulder: R / L

_____

- ☐ 3D Reconstruct
- ☐ SI Joint Injection: R / L

Fluoroscopy

- ☐ BE Water Soluble Enema
- ☐ Esophogram
- ☐ Cystogram
- ☐ Small Bowel follow through
- ☐ Upper GI
- ☐ Hysterosalpingogram
- ☐ Bone Survey
- ☐ VCUG
- ☐ MBS

Arthrogram (No MRI Imaging)

- ☐ Hip: R / L
- ☐ Shoulder: R / L
- ☐ Wrist: R / L

Arthrogram (With MRI Imaging)

- ☐ Hip: R / L
- ☐ Shoulder: R / L
- ☐ Wrist: R / L

Myelogram w/ CT

- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar

Bone Density

- ☐ DEXA
- ☐ Whole Body DEXA

US Procedures

- ☐ Joint Aspiration / Injection:

_____

- ☐ Paracentesis (w/o albumin)
- ☐ Thoracentesis: R / L (Includes 1V chest x-ray)
- ☐ Thyroid FNA

_____

- ☐ Lymph node biopsy

_____

- ☐ Other:_____

_____

PLACE PATIENT STICKER HERE

KootenaiHealth

To schedule please call | T: 208-625-6300 | F: 208-625-6301 | M-F 7am-5:30pm

Referral Attachment