WEST LITTLE ROCK EMERGENCY HOSPITAL

DIAGNOSTIC IMAGING ORDER FORM

17810 Chenal Parkway, Little Rock, AR 72223
Phone: 501-825-5603 Fax: 501-421-2519

PATIENT INFORMATION

Name: _____ **Date of Birth:** ___/___/___ **Weight:** _____lbs **Phone:**_____

Insurance/Policy #: _____ **Pre-Authorized #/Date Range:** _____

Ordering Physician (Please Print): _____ **Phone:** _____

Physician Signature: _____ **NPI#:** _____ **Date:** _____

Clinical Reason for Exam (ICD 10 Codes): _____ **CPT Code(s):** _____

Physician Reference for Results: ☐ Routine ☐ Urgent ☐ STAT ☐ Fax: _____

Notes: _____

MRI

Contrast: ☐ W/O ☐ W & WO

- ☐ Brain
  - ☐ Pituitary
  - ☐ IAC's
  - ☐ Seizure
  - ☐ MS
  - ☐ Tumor Eval
- ☐ Orbits
- ☐ Maxillofacial
- ☐ Neck Soft Tissue

• SPINE •

- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar
- ☐ Sacrum/ Coccyx

• VASCULAR •

- ☐ MRA Brain (WO Contrast Only)
- ☐ MRA Neck & Arch (WO Contrast Only)

• ORTHO •

- ☐ Upper Extremity (Specify): _____
  _____
- ☐ Lower Extremity (Specify): _____
  _____

• BODY •

- ☐ Abdomen (WO Contrast Only)
- ☐ MRCP
- ☐ Pelvis

☐ Other: _____

CT SCAN

Contrast: ☐ W ☐ W/O ☐ W & WO

- ☐ Brain
- ☐ Sinus/ Facial Bones
- ☐ Soft Tissue Neck
- ☐ Spine C T L
- ☐ Chest
- ☐ Abdomen/ Pelvis
- ☐ Renal Stone
- ☐ Urogram W/WO
- ☐ Adrenal Washout W/WO
- ☐ Bony Pelvis
- ☐ Upper/ Lower Extremity (Specify): _____
  _____

• CT ANGIO •

- ☐ Brain W/
- ☐ Neck W/
- ☐ Abdomen/ Pelvis W/
- ☐ Renal W/
- ☐ Chest W/
  - ☐ Aorta
  - ☐ PE
- ☐ Other: _____

ULTRASOUND

- ☐ Abdomen Complete
- ☐ Abdomen Limited
- ☐ Pelvis/ Doppler
- ☐ Renal/ Bladder
- ☐ Testicular
- ☐ Bladder
- ☐ Prostate
- ☐ Breast
- ☐ Pelvis W/ Endo Vaginal
  - ☐ WO Endo Vaginal
- ☐ Thyroid
- ☐ OB US:
  - ☐ Complete
  - ☐ Early
  - ☐ Limited
  - ☐ 3D/ 4D
  - ☐ Biophysical Profile

• VASCULAR •

- ☐ Catoids
- ☐ Arterial Doppler
  - ☐ Upper R L
  - ☐ Lower R L
- ☐ Venous Doppler
  - ☐ Upper R L
  - ☐ Lower R L

☐ Other: _____

DIGITAL X-RAY

- ☐ Skull
- ☐ Nasal
- ☐ Chest
- ☐ Abdominal Series
- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar
- ☐ Ribs R L
- ☐ Shoulder R L
- ☐ Clavicle R L
- ☐ Humerus R L
- ☐ Elbow R L
- ☐ Forearm R L
- ☐ Wrist R L
- ☐ Hand R L
- ☐ Femur R L
- ☐ Knee R L
- ☐ Tib/ Fib R L
- ☐ Sacrum + Coccyx
- ☐ SI Joints
- ☐ TMJ R L
- ☐ Pelvis
- ☐ Ankle R L
- ☐ Foot R L
- ☐ Calcaneus R L
- ☐ Toes R L
- ☐ Hip R L

☐ Finger R L 1 2 3 4 5

☐ Other: _____

This form must be completed, signed by a physician, and presented to the West Little Rock Emergency Hospital registration desk prior to any test being performed. Thank you!