



East Montgomery Imaging Center  
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R19.8  
195.51  
CPT 11250  
for EMIC use only  
CT thorax  
3 contrast

### PATIENT INFORMATION

Patient's Full Name Gong, Zheng DOB 6/22/96 Patient Phone: \_\_\_\_\_  
Ordering Physician Carol Stewart CRNP Office Phone 334 244 3281 Office Fax 334 244 3396  
Physician Signature/Date/Time [Signature] CRNP Cell Phone Number \_\_\_\_\_  
Reason for Exam (DIAGNOSIS) (+) TB skin test

### SPECIAL INSTRUCTIONS

- ☐ STAT call # \_\_\_\_\_ ☐ STAT fax # \_\_\_\_\_ ☐ Send CD ☐ Send patient back to office  
☐ EMIC to schedule ☐ EMIC to precertify exam ☐ Appt Date / Time \_\_\_\_\_  
☐ Obtain i-Stat Creatinine prior to intravenous contrast administration (criteria on reverse side)

### CT (Computerized Tomography)

- |                                                                                                 |                                                |
|-------------------------------------------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Brain W/O Contrast                                                     | <input type="checkbox"/> IAC's (Temporal Bone) |
| <input type="checkbox"/> Brain W/O & W Contrast                                                 | <input type="checkbox"/> Orbits                |
| <input type="checkbox"/> Sinus W/O                                                              | <input type="checkbox"/> Soft Tissue Neck W    |
| <input type="checkbox"/> Chest W/O                                                              | <input type="checkbox"/> Chest W               |
| <input type="checkbox"/> Abdomen W and Pelvis W (Routine)                                       |                                                |
| <input type="checkbox"/> Abdomen/Pelvis W/O (Stone Hunt)                                        |                                                |
| <input type="checkbox"/> Abdomen/Pelvis W/O & W (Hematuria Protocol)                            |                                                |
| <input type="checkbox"/> Abdomen W/O                                                            | <input type="checkbox"/> Abdomen W/O & W       |
| <input type="checkbox"/> Pelvis W/O                                                             | <input type="checkbox"/> Pelvis W              |
| <input type="checkbox"/> Cervical Spine <input type="checkbox"/> W/O <input type="checkbox"/> W | <input type="checkbox"/> Bony Pelvis           |
| <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> W/O <input type="checkbox"/> W   | <input type="checkbox"/> Other _____           |
| <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> W/O <input type="checkbox"/> W | <input type="checkbox"/> 3-D Reconstruction    |

### CTA (CT Angiography)

- |                                              |                                                 |
|----------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> CTA Brain (COW)     | <input type="checkbox"/> CTA Neck               |
| <input type="checkbox"/> CTA Abdominal Aorta | <input type="checkbox"/> CTA Renals             |
| <input type="checkbox"/> CTA Pelvis          | <input type="checkbox"/> CTA Runoff-Bil Lwr Ext |
| <input type="checkbox"/> CTA Chest (PE)      | <input type="checkbox"/> CTA Thoracic Aorta     |

### MRI (Magnetic Resonance Imaging)

- CONTRAST W/O \_\_\_\_\_ W&W/O \_\_\_\_\_
- |                                                                                                                               |                                                                                                                     |
|-------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Brain                                                                                                | <input type="checkbox"/> MRCP (NPO 6hrs)                                                                            |
| <input type="checkbox"/> IAC's                                                                                                | <input type="checkbox"/> Kidney                                                                                     |
| <input type="checkbox"/> Pituitary                                                                                            | <input type="checkbox"/> Liver                                                                                      |
| <input type="checkbox"/> Orbits                                                                                               | <input type="checkbox"/> Adrenals                                                                                   |
| <input type="checkbox"/> Chest Wall                                                                                           | <input type="checkbox"/> Hip <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilat   |
| <input type="checkbox"/> Brachial Plexus <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilat | <input type="checkbox"/> Foot <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilat  |
| <input type="checkbox"/> Pelvis                                                                                               | <input type="checkbox"/> Knee <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilat  |
| <input type="checkbox"/> Cervical Spine                                                                                       | <input type="checkbox"/> Ankle <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilat |
| <input type="checkbox"/> Lumbar Spine                                                                                         | <input type="checkbox"/> Wrist <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilat |
| <input type="checkbox"/> Thoracic Spine                                                                                       | <input type="checkbox"/> Other _____                                                                                |
| <input type="checkbox"/> Shoulder <input type="checkbox"/> with arthrogram                                                    | <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilat                                |

### MRA ANGIOGRAPHY

- |                                                          |                                         |
|----------------------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Intracranial - Circle of Willis | <input type="checkbox"/> Renal Arteries |
| <input type="checkbox"/> Carotids and Vertebrales        | <input type="checkbox"/> Other _____    |

### FLUOROSCOPY

- |                                             |                                          |
|---------------------------------------------|------------------------------------------|
| <input type="checkbox"/> GI Series          | <input type="checkbox"/> BE              |
| <input type="checkbox"/> GI and Small Bowel | <input type="checkbox"/> BE Air Contrast |
| <input type="checkbox"/> Small Bowel        | <input type="checkbox"/> IVP             |
| <input type="checkbox"/> Esophagram         | <input type="checkbox"/> Other _____     |

### NUCLEAR MEDICINE

- |                                                    |                                       |
|----------------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Bone Scan Whole Body      | <input type="checkbox"/> Renal        |
| <input type="checkbox"/> Three Phase Bone Scan     | <input type="checkbox"/> MUGA         |
| <input type="checkbox"/> Thyroid (uptake and scan) | <input type="checkbox"/> Liver/Spleen |
| <input type="checkbox"/> Hepatobiliary Scan (HIDA) | <input type="checkbox"/> Parathyroid  |
| <input type="checkbox"/> Gastric Emptying          | <input type="checkbox"/> Other _____  |

### ULTRASOUND

- |                                                                                  |                                                                                      |
|----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| <input type="checkbox"/> Obstetrical                                             | <input type="checkbox"/> Pelvic                                                      |
| <input type="checkbox"/> Pelvic/Transvaginal                                     | <input type="checkbox"/> Scrotum                                                     |
| <input type="checkbox"/> Abdomen Complete                                        | <input type="checkbox"/> Abdomen (RUQ)                                               |
| <input type="checkbox"/> Thyroid                                                 | <input type="checkbox"/> Hysterosonogram                                             |
| <input type="checkbox"/> Renal arteries                                          | <input type="checkbox"/> Renal / Kidney                                              |
| <input type="checkbox"/> Carotid                                                 | <input type="checkbox"/> Aorta                                                       |
| <input type="checkbox"/> Venous Doppler lower extremity                          | <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilat |
| <input type="checkbox"/> Venous Doppler upper extremity                          | <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilat |
| <input type="checkbox"/> Arterial Doppler lower extremity w/ segmental pressures |                                                                                      |
| <input type="checkbox"/> Infant Spine                                            |                                                                                      |
| <input type="checkbox"/> Other _____                                             |                                                                                      |

### ROUTINE X-RAYS

- |                                                                                       |                                                         |
|---------------------------------------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Chest                                                        | <input type="checkbox"/> Cervical Spine                 |
| <input type="checkbox"/> Abdomen Series                                               | <input type="checkbox"/> Thoracic Spine                 |
| <input type="checkbox"/> Ribs <input type="checkbox"/> LT <input type="checkbox"/> RT | <input type="checkbox"/> Lumbar Spine                   |
| <input type="checkbox"/> KUB                                                          | <input type="checkbox"/> Sinuses                        |
| <input type="checkbox"/> Skull                                                        | <input type="checkbox"/> Pelvis                         |
| <input type="checkbox"/> Thoracolumbar (Scoliosis)                                    | <input type="checkbox"/> Other _____                    |
| <input type="checkbox"/> Extremity (specify) _____                                    | <input type="checkbox"/> LT <input type="checkbox"/> RT |

### BONE DENSITY

- ☐ Bone Dexa Axial Skeleton

### ADDITIONAL INFORMATION