

THIS ORDER MUST BE PRESENTED AT THE TIME OF SERVICE



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

CT SCAN section containing sub-sections: CONTRAST, CT BRAIN / HEAD, CT FACE, CT NECK, CT Lung Screening, CT CHEST, CT SPINE, SPECIALTY EXAMS, CT ABDOMEN & PELVIS, CT ABDOMEN, CT PELVIS, CT EXTREMITIES.

MRI

MRI section containing sub-sections: MRI CONTRAST, NEURO, MR MUSCULOSKELETAL, MRI BODY, MR SPINE, MRA BODY.

Will patient require anesthesia or pediatric sedation? YES NO 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 Dialysis
YES NO Renal Disease or transplant
Does the patient have a Pacemaker or Implantable Cardioverter Defibrillator(ICD)? YES NO IF YES, please check box below (Required)
Initiate the Lifespan MRI Cardiovascular Implantable Electronic Devices (CIED) protocol for conditional pacemakers or pacemaker/implantable cardioverter defibrillators pre and post MRI.

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.



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  - 375 Wampanoag Trail
  - 146 West River Street
  - Rhode Island Hospital
  - Medical Office Center Building (MOC / Anne Pappas Center)
  - 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: \_\_\_\_\_

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-VEINUS**

- 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

**GENERAL RADIOLOGY**

**EXTREMITY**  RIGHT  LEFT

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

BONE DENSITY DEXA HT: \_\_\_\_\_ WT: \_\_\_\_\_

**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**

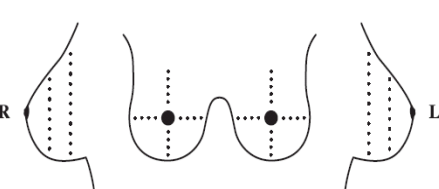
- Barium Enema  with air  without air
- Barium Swallow
- Modified Barium Swallow w/Speech Pathology
- Pouch-o-gram
- Small Bowel
- Upper GI
- Defecogram
- Fistulogram

**GU STUDIES**

- VCUG
- Retrograde urethrogram
- Urethrogram
- Cystogram
- Loopogram
- Other: \_\_\_\_\_

ORDER COMMENTS: \_\_\_\_\_

**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](mailto:imaging@lifespan.org) with your request.**

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