THIS PHYSICIAN ORDER MUST BE PRESENTED AT THE TIME OF SERVICE

Hasbro Children's Hospital
The Pediatric Division of Rhode Island Hospital
A Lifespan Partner

First Name: _____ Last Name: _____

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

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**

Will patient require sedation? ☐ YES ☐ NO ***If yes, please fill out sedation form***

CT SCAN

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

CT BRAIN / HEAD
☐ Brain ☐ Temporal Bone
☐ Mastoiditis
☐ Brain CTA

CT FACE
☐ Sinus ☐ Face ☐ Orbits

CT NECK
☐ Neck ☐ Neck CTA
☐ Cervical Spine – Levels _____

CT CHEST
☐ Chest
☐ High Resolution Chest
☐ Sternum/Sternoclavicular joints

CT SPINE
☐ Cervical Spine
☐ Thoracic Spine
☐ Lumbar Spine

CT ABDOMEN & PELVIS
☐ Abdomen & Pelvis
☐ Renal/Ureter Stone

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

CT PELVIS ONLY
☐ Pelvis ONLY (no abdomen)
☐ Acetabulum/hips
☐ Sacrum/Coccyx
☐ Pelvis CTA

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

MRI

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

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

MR MUSCULO/SKELETAL
SIDE: ☐ RIGHT ☐ LEFT
☐ Shoulder ☐ Hip
☐ Humerus ☐ Thigh
☐ Elbow ☐ Knee
☐ Forearm ☐ Lower Leg
☐ Wrist ☐ Ankle
☐ Hand ☐ Foot
☐ Arthrogram _____
☐ upper ☐ lower
☐ Other _____

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

MRA BODY
☐ **MRA Chest:** _____
☐ **MRA Abdomen:** _____
☐ **MRA Pelvis:** _____
☐ **MRA Peripheral:** _____

MR SPINE
☐ Cervical
☐ Thoracic
☐ Lumbar
☐ Entire Spine
☐ Brachial Plexus *(MRI Chest study)*
☐ RIGHT ☐ LEFT
MRA Spine: _____
MRA Extremity
Please specify:
_____

*To request MRI Cardiac form please contact imaging@lifespan.org with your request
**If patient has a pacemaker or is Pregnant please contact MRI and speak with an attending Radiologist at 401-444-4881

If patient has any of the following conditions, the patient will need a creatinine level drawn within 6 weeks of appointment.
☐ **YES** ☐ **NO** **Hypertension**
☐ **YES** ☐ **NO** **Renal Disease or transplant**
☐ **YES** ☐ **NO** **Diabetes**
☐ **YES** ☐ **NO** **Dialysis**

Creatinine Level within six weeks: _____ **Date of labs:** _____ **eGFR (if <60):** _____

For physician inquiries or to speak with a Radiologist please call 401-444-2404

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**Physician Signature: ****_____ Date: _____

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ULTRASOUND

ABDOMEN
☐ Abdomen (all organs) ☐ vascular evaluation
☐ Appendix with Abdomen (all organs)
☐ Right Upper Quadrant (liver/GB/kidney) ☐ vascular evaluation
☐ Renal (Includes Bladder Imaging)
☐ Renal with Doppler evaluation
☐ Renal Transplant with Doppler evaluation

SMALL PARTS
☐ Thyroid/Parathyroid/Neck
☐ Thyroid Biopsy **Location**_____/**or** ☐**Determined by Radiologist**
☐ Breast ☐ RIGHT ☐ LEFT
Breast ultrasounds age 10 or less. Older patients imaged in breast center.

CHEST
☐ Chest

MALE PELVIS
☐ Testes with blood flow Doppler evaluation
☐ Pelvis

FEMALE PELVIS
☐ Pelvic Transabdominal scan only
☐ Pelvic Transabdominal & Transvaginal ☐ Doppler ovarian

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

OTHER (please specify)
☐ Spine-Sacral Dimple ☐ Hips-DDH
☐ Cranial ☐ Non-Vascular Extremity(ex. mass)
☐ Hip-Joint Effusion ***(Radiologist Approval Required)***
Other_____

GENERAL RADIOGRAPHY

EXTREMITY ☐ RIGHT ☐ LEFT
☐ Hand
☐ Finger _____
☐ Wrist
☐ Forearm
☐ Elbow
☐ Orbits
☐ Humerus
☐ Shoulder
☐ Clavicle
☐ Scapula
☐ Neck Soft Tissue
☐ Bone Age
☐ Pelvis
☐ Hip
☐ Hip A/P Frog
☐ Femur
☐ Knee
☐ Tibia/Fibula
☐ Ankle
☐ Foot

☐ Other _____

ORDER COMMENTS: _____
_____
_____

☐ Chest (2 views)
☐ Ribs ☐ RIGHT ☐ LEFT
☐ Foreign Body-aspirated/ingested
☐ Abdomen
  ☐ 2 View
  ☐ 1 View
☐ Spine
  ☐ Cervical
  ☐ Lumbar
  ☐ Thoracic
  ☐ Thoracolumbar
  ☐ Scoliosis
☐ Sinus
☐ Bone Survey Child Abuse
☐ Bone Survey Skeletal Dysplasia
☐ Scanogram

SKULL
☐ More than 4 views
☐ Less than 4 views

SHUNT SERIES (select all 3)
☐ Skull
☐ Abdomen AP/LAT
☐ Chest PA/LAT

GI/FLUORO STUDIES
☐ Contrast Enema
☐ Barium Swallow
☐ Cine Barium Swallow
☐ Chest Airway Fluoro
☐ Small Bowel Series
☐ Upper GI
☐ Upper GI w/small Bowel Series
☐ Fistula Tract/Gtube

GU STUDIES
☐ VCUG
☐ Other: _____

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