

**RADIOLOGY PROCEDURE ORDER FORM**

\*\*\*\* ATTENTION PATIENT: PLEASE BRING THIS FORM TO YOUR APPOINTMENT\*\*\*\*

<input type="checkbox"/> <b>UIMC Hospital</b> 1740 W. Taylor St., Rm 2400 Chicago, IL 60612 CT, IR, Nuclear Medicine, X-Ray, Ultrasound, Fluoroscopy	<input type="checkbox"/> <b>UIMC Outpatient Care Center (OCC)</b> 1801 W. Taylor St. Chicago, IL 60612 <b>Suite 1A - MRI</b> <b>Suite 2C - CT, Mammography, X-Ray</b>	<input type="checkbox"/> <b>UIMC Advanced Imaging Center (AIC)</b> 2242 W. Harrison St. Chicago, IL 60612 <b>Suite 103 – MRI, PET/CT, Ultrasound</b>
<b>Patient Name</b>		<b>Date of Birth</b>
<b>Patient Phone #</b>		<b>Alternate Phone #</b>
Appointment Date/Time		Insurance

<b>Procedure Requested</b>	
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<input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> Nuclear Medicine <input type="checkbox"/> IR/Angiography <input type="checkbox"/> X-Ray <input type="checkbox"/> Fluoroscopy <input type="checkbox"/> PET/CT <b>Mammography</b> <input type="checkbox"/> Screening <input type="checkbox"/> Diagnostic* <small>*Breast ultrasound may be done at the discretion of the radiologist</small> <b>Ultrasound</b> <input type="checkbox"/> Scrotum with Doppler <input type="checkbox"/> Pelvis – Trans Abdominal, Transvaginal, Doppler <input type="checkbox"/> Vascular <input type="checkbox"/> Other : _____	<p style="text-align: center;"><b>Contrast</b></p> Pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/> Claustrophobic? Yes <input type="checkbox"/> No <input type="checkbox"/> Do we have permission to give IV or PO contrast? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no, stop here. If yes, continue with questions below.</i> <b>Does the patient have any of the following risk factors?</b> Hypertension, diabetes, kidney disease, family history of kidney failure, recent kidney surgery, or age > 60 years <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, must have SCr and GFR: <ul style="list-style-type: none"> <li>• Within <b>6 weeks</b> of study for <b>MRI</b></li> <li>• Within <b>30 days</b> of study for <b>CT / IR / Angiography</b></li> </ul> Serum creatinine _____ GFR _____ Date _____ Patient on dialysis? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what kind? Hemodialysis <input type="checkbox"/> Peritoneal dialysis <input type="checkbox"/> <b>MRI / MRA: For GFR &lt;30 or dialysis, informed consent required.</b> <b>Please consult the radiologist prior to scheduling.</b> <hr/> Does patient have <b>contrast allergy</b> ? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what kind of contrast is the patient allergic to? MRI <input type="checkbox"/> Iodine <input type="checkbox"/> <i>If patient has contrast allergy, contact Radiology at number listed below.</i> Does patient have asthma? Yes <input type="checkbox"/> No <input type="checkbox"/> List other allergies:  Patient weight: _____ height: _____
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ICD-9 Code / Clinical History

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Ordering Clinic	Attending Physician Name (please print)	Pager or Contact Number
Ordering Physician Signature	Pager or Contact Number	Date/Time

**Radiology Scheduling 312-413-4900 or 1-877-456-UIMC (8462)**

Angiography or Interventional Radiology Scheduling: 312-413-3737 or 312-996-0241

Fax 312-996-8154    www.uillinoismedcenter.org/imaging

Please refer to the other side for directions and instructions

UI-3335 (01/11)



