# Teton Radiology *advanced medical imaging*

☐ Idaho Falls: tel (208) 524-7237 fax (208) 522-3017 ☐ Rexburg: tel (208) 356-4888 fax (208) 356-4720

| Patient: | Phone #: | Date of Birth: |
|---|---|---|
| Date of Service: | Intent of Imaging: | |

## Step 1: Please select an exam

### CT
Abdomen & Pelvis
Abdomen Only
Chest
Chest - High Resolution
Enteroclysis
Head
KUB - Plain Abd Pelvis
Myelogram [C / T / L]
Pelvis Only
Sinus
Soft Tissue Neck
Spine [C / T / L]
Urogram

### CT-Guided Biopsy
Bone Biopsy
Liver Biopsy
Lung Biopsy

### CT Angiography
Abdomen
Abdomen w/ runoff
Carotid
Chest/Pulmonary
Head

### DEXA
Diagnostic
Screening

### Digital X-Ray
Specify Body Part

_____

### Fluoroscopy
Arthrogram
Barium Enema
Barium Swallow
Chest Fluoroscopy
Modified Bar Swallow
Oral Enteroclysis
Small Bowel FT
Upper GI
Urethrogram
VCUG

### Interventional
Oncology Procedure
Consult
Epidural Steroid
Injection [C / T / L]
Hip Injection
Lumbar Puncture
Nerve Root Block
Pelvic Congestion
Syndrome Consult
PICC Line
Peripheral Vascular
Disease Screening
Port Place/Removal
RF Ablation
SI Joint Injection
Uterine Fibroid
Embolization Consult
Venous Ablation
Vertebroplasty

### Mammography
Diagnostic / Screening

### MRI
Contrast?
[Y / N / At Rad Discretion]
Body
Abdomen
Cardiac
Chest
MRCP
Neck
Pelvis
Breast
Extremity - non joint
Lower
Upper
Head
Brain
IACs
Orbits
Pituitary
Joints [L / R]
Ankle
Elbow
Foot
Hip
Knee
Shoulder
TMJ
Wrist
Spine [C / T / L]

### MR Arthrogram
Hip
Knee
Shoulder
Wrist

### MR Angiography
Aorta Thoracic Abd.
Carotid
Head
Peripheral
Renal

### Ultrasound
Abdomen
Breast
Carotid
OB
Pelvis
Renal
Scrotum
Thyroid
Venous [Arm / Legs]

### Ultrasound-Guided Biopsy
Breast Biopsy
Liver Biopsy
Thyroid FNA

Notes:

## Step 2: General Order

***Symptoms***

***Anatomical Area*** Head Chest Rt Upper Quadrant Rt Lower Quadrant Lt Upper Quadrant Lt Lower Quadrant Deep Superficial
C / T / L Spine Breast Rt Upper Extremity Rt Lower Extremity Lt Upper Extremity Lt Lower Extremity Proximal Distal

***Location (specific site)***

***Laterality*** Right Left Bilateral

***History*** *Present Illness *Historical Illness *If diabetes, complete the "Diabetes" section.*

***Severity*** Acute Chronic *Traumatic Non-Traumatic *If traumatic, complete the "Injury/Fracture" section.*

### *If Applicable: Injury/Fracture*

*Type of Injury* Assault Accident Laceration Contusion Fracture

*Fracture* Pathologic Traumatic Idiopathic

*Encounter* Initial Subsequent Sequelae

*Healing* Routine Delayed Non-Union Mal-Union

*Intent of Imaging* Diagnostic for Tx Healing Status Evaluation of residual issue

Other: _____

*Incident* How and where did the injury happen?

### *If Applicable: Cancer/Neoplasm*

Malignant In-Situ Benign Uncertain Behavior

*If Malignant* Please note personal Hx below.

*Growth Type* Neoplasm New Growth

Tumor (type): _____

*Other Relevant Info*

### *If Applicable: Diabetes*

Controlled Uncontrolled

Type 1 Type 2 Gestational

### *If Applicable: Pregnancy*

Disease Injury

*If injury? Fill out "Injury/Fracture" section.*

How is the condition affecting pregnancy?

*Obstetric Ultrasound*

Trimester: 1st 2nd 3rd

Weeks: < 14 weeks > 14 weeks

Notes for OB order:

| Notes: | Referring Provider Signature | Date |
|---|---|---|