Premier Health

Miami Valley Hospital
Atrium Medical Center
Upper Valley Medical Center

OUTPATIENT SERVICES
Medical Imaging/Diagnostic Testing

To schedule an appointment call: (937) 499-7364, (855) 887-7364 (toll free) or fax order to: (937) 641-2336

*Indicates items required for a complete order

***Patient Name (printed):**		***Date of Birth:**
Patient Phone #:	**Patient Alternate #:**	**Insurance:**
***ICD Diagnosis Code(s) Symptoms or Complaint:**		
***Physician Name (printed):**	***Date:**	***Time:**
***Physician Signature:**	**Special Instructions:**	

GENERAL XRAY

	Abdomen/Series			
	Abdomen/KUB			
	Chest			
	Sinus			
	Pelvis			
	Skull			
	Soft Tissue neck			
	Spine ☐ Cervical ☐ Lumbar ☐ Thoracic ☐ w/Obliques ☐ w/Flexion & Extension			
	Sacrum/Coccyx			
	Ankle	☐ R	☐ L	☐ BIL
	Elbow	☐ R	☐ L	☐ BIL
	Femur	☐ R	☐ L	☐ BIL
	Foot	☐ R	☐ L	☐ BIL
	Forearm	☐ R	☐ L	☐ BIL
	Hand	☐ R	☐ L	☐ BIL
	Hip	☐ R	☐ L	☐ BIL
	Humerus	☐ R	☐ L	☐ BIL
	Knee	☐ R	☐ L	☐ BIL
	Lower Leg	☐ R	☐ L	☐ BIL
	Ribs	☐ R	☐ L	☐ BIL
	Shoulder	☐ R	☐ L	☐ BIL
	Wrist	☐ R	☐ L	☐ BIL
	Other – Specify: _____			

FLUOROSCOPIC PROCEDURES

	Arthrogram: specify _____ ☐ w/CT ☐ w/MRI
	Cystogram ☐ voiding
	Hysterosalpingogram
	Esophagram
	Upper GI
	Small Bowel
	Barium Enema/Colon ☐ w/air
	Intravenous Pyelogram (IVP)
	Modified barium swallow/video fluoroscopy

MAMMOGRAPHY

	Screening Mammogram with 3D			
	Diagnostic Mammogram	☐ R	☐ L	☐ BIL
	Breast Imaging Workup/Diagnostic/Mammo			
	☐ Breast US if indicated			
	☐ Image Guided Asp./Biopsy if indicated			
	☐ Breast MRI if indicated			
	☐ Ductogram if indicated			
	Stereotactic Biopsy	☐ R	☐ L	☐ BIL
	Needle Localization	☐ R	☐ L	☐ BIL
	US Guided Breast Biopsy	☐ R	☐ L	☐ BIL
	Dexa Bone Density			
	Trabecular Bone Score			
	Other – Specify: _____			

ULTRASOUND

	Abdomen Complete			
	Abdomen Limited (ie: RUQ)			
	Biophysical Profile			
	Bladder			
	Breast Limited	☐ R	☐ L	☐ BIL
	Breast Complete	☐ R	☐ L	☐ BIL
	Kidney			
	OB ☐ Transvaginal if indicated			
	Pelvis ☐ Transvaginal if indicated			
	Testicular			
	Thyroid			
	Liver Elastography			
	Other – Specify: _____			

VASCULAR ULTRASOUND

	ABI only
	Arterial Duplex
	Arterial Doppler Study/PVR ☐ Lower ☐ Upper
	Carotid
	Vein Mapping ☐ Lower ☐ Upper ☐ R ☐ L ☐ BIL
	Venous Doppler Studies ☐ Lower ☐ Upper ☐ R ☐ L ☐ BIL
	Other – Specify: _____

CARDIOLOGY

	12-Lead ECG
	24-Hour Holter Monitor
	48-Hour Holter Monitor
	2-D Echo
	ECHO ☐ Treadmill ☐ Dobutamine
	Stress EKG (Treadmill only)
	Cardiac Nuclear Stress: ☐ Medicated ☐ Treadmill
	MUGA Scan
	Event Monitor
	Other – Specify: _____

RESPIRATORY

	ABG ☐ w/O2 (specify _____lpm) ☐ w/o O2
	Complete PFT (includes volumes and diffusion)
	Complete PFT with Bronchodilator (includes volumes, diffusion and bronchodilator)
	Spirometry (includes SVC and FVC)
	Spirometry with bronchodilator (includes SVC, FVC and bronchodilator)
	Pulmonary Exercise Stress test
	MVV (maximum voluntary ventilation)
	Methacholine Challenge
	PI Max/PE Max (also called MIP/MEP)
	Other – Specify: _____

EMG

	EMG/NCS ☐ Lower ☐ Upper ☐ R ☐ L ☐ BIL

NEURODIAGNOSTICS

	AEEG – Ambulatory EEG
	Evoked Potential Auditory
	Evoked Potential Visual
	Evoked Potential Somatosensory Upper Ext
	Evoked Potential Somatosensory Lower Ext
	Routine EEG

NUCLEAR MEDICINE/PET

	Bone Scan ☐ Whole Body ☐ 3-phase ☐ Limited
	Cardiac Stress: ☐ Pharmacological ☐ Treadmill
	MUGA Scan
	Gall Bladder ☐ w/CCK ☐ w/o CCK
	Gastric Emptying ☐ Liquid ☐ Solid
	Gallium
	Lung Scan ventilation/perfusion
	Parathyroid
	Renal – Specify: ☐ Flow/function ☐ x/Lasix ☐ w/Captopril
	Thyroid Uptake/Scan ☐ Single ☐ Multi
	PET/CT-Specify: _____
	Other – Specify: _____

CT

All exams listed below are contrast per radiologist protocol. For specific contrast request, indicate under Other.

	Abdomen
	Abdomen/Pelvis
	Chest
	Extremity-Specify:
	Head
	Neck
	Pelvis
	Spine: ☐ Cervical ☐ Thoracic ☐ Lumbar
	CT Angiography-Specify:
	CT Lung Screening
	Calcium Scoring
	*Other – Specify: _____

MRI

All exams listed below are contrast per radiologist protocol. For specific contrast request, indicate under Other.

	Abdomen			
	Ankle	☐ R	☐ L	☐ BIL
	Brachial Plexus			
	Breast			
	Fast Breast Screening			
	Chest			
	Elbow	☐ R	☐ L	☐ BIL
	Extremity (non joint) Specify:			
	Head/Brain			
	Hip	☐ R	☐ L	☐ BIL
	Knee	☐ R	☐ L	☐ BIL
	Pelvis			
	Shoulder	☐ R	☐ L	☐ BIL
	Soft Tissue Neck			
	Spine: ☐ Cervical ☐ Thoracic ☐ Lumbar			
	Wrist	☐ R	☐ L	☐ BIL
	MR Angiography Specify:			
	*Other – Specify: _____			

Scheduled Date _____ Time _____ Comments _____