



Appointment Scheduling- 301-754-8200
Monday-Friday 8am-6pm

Germantown Silver Spring

PLEASE BRING THIS FORM WITH YOU TO YOUR

PLEASE PRINT CLEARLY

TODAY'S DATE: _____

APPOINTMENT OR FAX IT TO: 301-754-8201

| | | |
|------------------------|-------------------------------|----------------------------|
| PATIENT NAME: | ORDERING PHYSICIAN: | DIAGNOSIS/REASON FOR TEST: |
| DATE OF BIRTH | ORDERING PHYSICIAN SIGNATURE: | STAT REQUEST FAX: |
| PREFERRED PHONE NUMBER | PHYSICIAN PHONE #: | STAT Request Fax: |

PHYSICIAN'S WRITTEN ORDER

DIAGNOSTIC X-RAY (walk-ins)

Chest: PA / Lateral 1 view
 Abdomen: Flat Flat/erect
 Spine : C T L P
 Extremity: LF RT BILAT.
 Body Part
 Other:

MRI AND CT PATIENTS WITH CONTRAST

For patients who are diabetic, have kidney issues, or are age 65+, please fax a copy of the Bun/Creatinine lab results with this order to fax number 301-754-7354, 2 days prior to the test.

MRI AND CT PATIENTS WITH CONTRAST

CONTRAST: W W/O W/O & W AS NEEDED

| MRI | CT Scan |
|---|--|
| <input type="checkbox"/> Brain: <input type="checkbox"/> W/ attention to IAC <input type="checkbox"/> w/ atten. to Pituit. | <input type="checkbox"/> Head <input type="checkbox"/> Chest: |

ULTRASOUND

Abdomen Complete

Externity Arterial Doppler:

Upper Right Bilat
 Lower Left
 Pelvis Non-OB
 Abdomen Non-OB
 Transvaginal
 Hips Infant Dynamic
 Spinal Canal
 Scrotum
 Thyroid/Neck FNA

Externity Venous Doppler:

Upper Right Bilat
 Lower Left

Retroperitoneum:

Complete
 Bladder Kidney Aorta
 Sonohysterogram
 Carotid
 Other: _____

| | |
|---|--|
| <input type="checkbox"/> Spine: <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar | Spine: <input type="checkbox"/> Neck Soft Tissue <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar |
| <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> MRCP <input type="checkbox"/> Pelvis <input type="checkbox"/> Breast <input type="checkbox"/> Orbit <input type="checkbox"/> Neck | <input type="checkbox"/> Abdomen Only <input type="checkbox"/> Pelvis Only <input type="checkbox"/> Abdomen and Pelvis <input type="checkbox"/> Pelvis <input type="checkbox"/> Breast <input type="checkbox"/> Orbit <input type="checkbox"/> Neck |
| <input type="checkbox"/> Externity <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Body Part: | <input type="checkbox"/> Biopsy: <input type="checkbox"/> Abdomen <input type="checkbox"/> Lung <input type="checkbox"/> Liver <input type="checkbox"/> Renal |
| <input type="checkbox"/> MRA (Specify) <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Sinus <input type="checkbox"/> Maxillofacial <input type="checkbox"/> CTA: <input type="checkbox"/> Neck <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Other: _____ |

Other Test or Instructions:

Fluoroscopy

Upper GI
 Upper GI w/Small Bowel
 Small Bowel only
 Pharyngogram/Video Swallow
 Esophagram
 IVP
 VCUG

Barium Enema:

Air Contrast Single Contrast
 Hysterosalpingogram

Other Test or Instructions:

Nuclear Medicine

| | |
|---|---|
| <input type="checkbox"/> Abcess (Inflammatory) locatization <input type="checkbox"/> Bone <input type="checkbox"/> Whole Body <input type="checkbox"/> 3 Phase <input type="checkbox"/> Thyroid Consult and Treatment with I-131 <input type="checkbox"/> Thyroid with Uptake <input type="checkbox"/> Neck and Chest Survey with I-131 <input type="checkbox"/> Parathyroid <input type="checkbox"/> Stress Test with Nuclear <input type="checkbox"/> Stress Test with Pharmacological <input type="checkbox"/> Stress Test with Thalium <input type="checkbox"/> Lexiscan | <input type="checkbox"/> Lung B/Q <input type="checkbox"/> Quantitative <input type="checkbox"/> Liver/Spleen <input type="checkbox"/> Gallbladder (HIDA) <input type="checkbox"/> with EF <input type="checkbox"/> Renal <input type="checkbox"/> RVH (Captopril) <input type="checkbox"/> Lasix <input type="checkbox"/> Tumor Localization <input type="checkbox"/> Gastric Emptying <input type="checkbox"/> MUGA (cardiac blood pool) <input type="checkbox"/> Cysternogram <input type="checkbox"/> Lymphoscintigraphy <input type="checkbox"/> Surgery @ HC/Date_____ <input type="checkbox"/> VP Shunt |
|---|---|