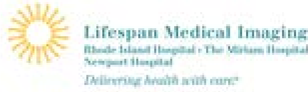
THIS ORDER MUST BE PRESENTED AT THE TIME OF SERVICE



Please select if you have a location preference:
- ☐ The Miriam Hospital
- ☐ 195 Collyer St
- ☐ 900 Warren Ave (Coastal Building)
- ☐ 375 Wampanoag Trail
- ☐ 146 West River Street
- ☐ Rhode Island Hospital
- ☐ Medical Office Center Building (MOC)
- ☐ Newport Hospital
- ☐ Portsmouth Imaging Center

Please contact patient to make appointment ☐ Yes ☐ No

☐ STAT ☐ ROUTINE EXPECTED DOS:_______________

First Name: ____________________________ Last Name: ____________________________

DOB:_______________ Phone: ____________________ Insurance Plan /Plan #:: ____________________

Patient's Address: ____________________________ City/State: ____________________ Zip Code: __________

ICD 10 Codes (REQUIRED):____________________________

Signs/Symptoms /Reasons for Exam (REQUIRED): ____________________________

Ordering Provider (printed): ____________________________ Office Phone: ____________________

**Provider Signature: ****____________________________ Date: ____________________

****MUST BE ORIGINAL SIGNATURE ; STAMPED SIGNATURES NOT ACCEPTED**

CT SCAN

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

CT BRAIN / HEAD
- ☐ Brain ☐ Temporal Bone
- ☐ Mastoid ☐ Brain Venogram
- ☐ Gamma Knife
- ☐ Brain CTA

CT FACE
- ☐ Sinus ☐ Orbits
- ☐ Face

CT NECK
- ☐ Neck ☐ Neck CTA

CT Lung Screening
- ☐ Lung Cancer Screening
- ☐ Lung Cancer Screening Follow-up

By signing this order, you are certifying that:
☒ The patient is asymptomatic with no signs or symptoms of lung cancer.
☒ The patient was informed of the importance of smoking cessation and/or maintaining smoking abstinence, including the offer of Medicare-covered tobacco cessation counseling services, if applicable

CT CHEST
- ☐ Chest
- ☐ High Resolution Chest
- ☐ Pulmonary embolus
- ☐ Aortic Dissection
- ☐ Chest CTA

CT SPINE
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine
- ☐ Post Myelogram ________ spine

SPECIALTY EXAMS
- ☐ CT Virtual Colonoscopy
- ☐ CT Enterography
- ☐ Calcium Scoring
- ☐ Pulmonary Vein Map
- ☐ CTA Coronary

CT ABDOMEN & PELVIS
- ☐ Abdomen & Pelvis
- ☐ Abdomen Pelvis Venogram
- ☐ Renal/Ureter Stone
- ☐ Hematuria
- ☐ CTA Endoleak

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

CT PELVIS
- ☐ Pelvis ONLY (no abdomen)
- ☐ Pelvis CTA

CT EXTREMITIES ☐ RIGHT ☐ LEFT
- ☐ Wrist
- ☐ Elbow
- ☐ Shoulder
- ☐ Hips
- ☐ Femur
- ☐ Knee
- ☐ Tibia/Fibula
- ☐ Ankle
- ☐ Foot /Calcaneous
- ☐ __________ Arthrogram w/intra-articular injection
- ☐ Lower Extremity "Run-Off" CTA Levels: ___________
- ☐ Upper Extremity CTA
- ☐ Upper Extremity Venogram
- ☐ **Other**____________________

MRI

MRI CONTRAST ☐ With & Without ☐ Without

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

MR MUSCULOSKELETAL

SIDE: ☐ RIGHT ☐ LEFT
- ☐ Shoulder ☐ Hip
- ☐ Humerus ☐ Thigh
- ☐ Elbow ☐ Knee
- ☐ Forearm ☐ Lower Leg
- ☐ Wrist ☐ Ankle
- ☐ Hand ☐ Foot
- ☐ ________ Fingers
- ☐ ________ Toes
- ☐ Arthrogram ______________ w/intra-articular injection *Specify joint:* ______________
- ☐ Neurography *Specify area:* ______________

MRI BODY
- ☐ Chest ☐ Adrenals
- ☐ Liver: __________ ☐ Kidneys
- ☐ MRCP/Pancreas
- ☐ Abdomen: ______________
- ☐ Elastography
- ☐ Fetal
- ☐ Pelvis: ______________
- ☐ MR Enterography ***(Abdomen+Pelvis Study)***

MRA BODY
- ☐ **MRA Chest:** ______________
- ☐ **MRA Abdomen:** ______________
- ☐ **MRA Pelvis:** ______________
- ☐ **MRA Extremity** ***Please specify:*** ____________________

MR SPINE
- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar
- ☐ Entire Spine *(C, T, & L spine)*
- ☐ Brachial Plexus *(MRI Chest study)*
  - ☐ RIGHT ☐ LEFT

MRA Spine: ______________

****MRI CARDIAC-Use detailed form***
****MRI BREAST- Use detailed form***

Has patient attempted exam with anxiolysis? ☐YES ☐NO
Will patient require anesthesia or pediatric sedation? ☐YES ☐NO If yes, please fill out sedation form.

If patient has any of the following conditions, the patient may need a creatinine level drawn prior to appointment. Please fax creatinine to 444-5732 if acquired outside Lifespan Laboratories.
- **☐YES ☐NO Dialysis**
- **☐YES ☐NO Renal Disease or transplant**

Does the patient have a Pacemaker or Implantable Cardioverter Defibrillator(ICD)? ☐YES ☐NO IF YES, please check box below (Required)
☐ Initiate the Lifespan MRI Cardiovascular Implantable Electronic Devices (CIED) protocol for conditional pacemakers or pacemaker/implantable cardioverter defibrillators pre and post MRI.

If patient is pregnant and within 1st trimester, please contact the MRI department and speak to an attending radiologist 444-4881.
***To request MRI Cardiac or MRI Breast forms please contact imaging@lifespan.org with your request.**

THIS PHYSICIAN ORDER MUST BE PRESENTED AT THE TIME OF SERVICE

Please select if you have a location preference:

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- ☐ 146 West River Street
- ☐ Rhode Island Hospital
- ☐ Medical Office Center Building (MOC / Anne Pappas Center)
- ☐ Newport Hospital
- ☐ Portsmouth Imaging Center

Please contact patient to make appointment ☐ Yes ☐ No

☐ STAT ☐ ROUTINE EXPECTED DOS:_______________

First Name: ______________________________ Last Name: ______________________________

DOB:____________ Phone: ______________ Insurance Plan /Plan #:: ______________________

Patient's Address: ______________________________ City/State: ________________ Zip Code: _________

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**

ULTRASOUND

ABDOMEN
- ☐ Abdomen Complete (with vascular evaluation if needed)
- ☐ Abdomen w/ Contrast
- ☐ Right Upper Quadrant Limited (with vascular evaluation if needed)
- ☐ CCK GB ejection fraction (RIH MOC ONLY)
- ☐ Renal with bladder (Post Void Residual)
- ☐ Renal with blood flow (resistive index) Doppler
- ☐ Renal - no vascular evaluation
- ☐ Renal-Complete Doppler- RAS
- ☐ Renal Transplant with Doppler evaluation
- ☐ Abdominal Aorta Follow up ☐ Abdominal Aorta Screening
- ☐ Liver with Doppler and Elastography
- ☐ Chest

SMALL PARTS
- ☐ Thyroid/Parathyroid
- ☐ Palpable Lump (designated area to be evaluated)________________
- ☐ Thyroid Biopsy **Location**______________________/or ☐**Determined by Radiologist**

OTHER (please specify)
- ☐ Non-Vascular Extremity Other__________________________
- ☐ Groin/Hernia __________________________________
- ☐ Palpable Lump (designated area to be evaluated)________________
- ☐ MSK (please specify)________________________________
- ☐ ABI ***For ABI's to be scheduled at RIH call 444-5194***

MALE PELVIS
- ☐ Testes (with blood flow Doppler evaluation if needed)
- ☐ Pelvis ☐ Pelvis– Post Void Residual only
- ☐ Prostate ☐ Prostate Bx

FEMALE PELVIS
- ☐ Transabdominal (with Transvaginal and/or Doppler eval. if needed)
- ☐ Transvaginal (with Doppler evaluation if needed)
- ☐ OB (less than 14 weeks) LMP ______________________
- ☐ OB (greater than 14 weeks) EDD______________________
- ☐ OB limited ______________________________
- ☐ OB other________________________________
- ☐ Pelvis for Post Void Residual only

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

VASCULAR-ARTERIAL
- ☐ Carotid ☐ Temporal Arteries
- ☐ Upper Extremity Arterial ☐ RIGHT ☐ LEFT ☐ BILATERAL
- ☐ Lower Extremity Arterial ☐ RIGHT ☐ LEFT ☐ BILATERAL

CEREBROVASCULAR
- ☐ Transcranial Doppler Complete
- ☐ Transcranial Doppler Emboli WO Microbubble Injection
- ☐ Transcranial Doppler Emboli W Microbubble Injection
- ☐ Transcranial Sickel Cell

GENERAL RADIOLOGY

EXTREMITY ☐ RIGHT ☐ LEFT
- ☐ Hand
- ☐ Wrist
- ☐ Forearm
- ☐ Elbow
- ☐ Humerus
- ☐ Shoulder
- ☐ Clavicle
- ☐ Scapula
- ☐ Finger (Specify)______
- ☐ Pelvis
- ☐ Hip
- ☐ Femur
- ☐ Knee
- ☐ Tibia/Fibula
- ☐ Calcaneus
- ☐ Ankle
- ☐ Foot
- ☐ Toe (Specify) _________

☐ **BONE DENSITY DEXA HT:**_________**WT:**__________

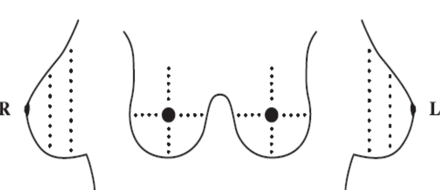
ORDER COMMENTS: ______________________________
____
____

- ☐ Chest specify:______________
- ☐ Ribs ☐ RIGHT ☐ LEFT
- ☐ Foreign Body
- ☐ Abdomen
  - ☐ Flat & Upright
  - ☐ Kidney/Ureters/Bladder(KUB)
- ☐ Spine
  - ☐ Cervical
  - ☐ Lumbar
  - ☐ Thoracic
  - ☐ Thoracolumbar
  - ☐ Scoliosis
- ☐ Sinus
- ☐ Bone Survey
- ☐ Metastatic Bone Series
- ☐ Scanogram
- ☐ Shunt Series

GI/FLUORO STUDIES
- ☐ Barium Enema
  - ☐with air ☐without air
- ☐ Barium Swallow
- ☐ Modified Barium Swallow w/Speech Pathology
- ☐ Pouch-o-gram
- ☐ Small Bowel
- ☐ Upper GI
- ☐ Defecogram
- ☐ Fistulogram

GU STUDIES
- ☐ VCUG
- ☐ Retrograde urethrogram
- ☐ Urethrogram
- ☐ Cystogram
- ☐ Loopogram
- ☐ Other: ______________________

BREAST IMAGING



Date of last exam:__________
- ☐ Screening Mammography
- ☐ Dense Breast Screening Ultrasound
- ☐ Mammography Diagnostic Bilateral/PRN Ultrasound
- ☐ Mammography Diagnostic Unilateral/PRN Ultrasound ☐ RIGHT ☐LEFT
- ☐ Breast Ultrasound ☐ RIGHT ☐ LEFT ☐ BILATERAL

  Location: ________________________

- ☐ RIGHT ☐ LEFT
- ☐ Ultrasound Guided Biopsy
- ☐ Cyst Aspiration
- ☐ Fine Needle Aspiration
- ☐ Stereotactic Biopsy
- ☐ Consultation w/imaging or biopsy prn

To request MRI Breast forms please contact imaging@lifespan.org with your request.