OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

RADIOLOGY DEPARTMENT
Email orders to radiology.orders@ocsri.org
OR fax orders to 918-505-3260

RADIOLOGY ORDER FORM

Patient Name (Last): _____ (First): _____

Patient Address: _____

DOB: _____ SSN: _____ Phone (Home): _____ (Cell): _____

Ordering Physician: _____ Clinical History: _____

Pre-Authorization #: _____ Insurance Company: _____

ICD9 Code: _____ Need by Date: _____

Allergies: _____ Diabetic: ☐ Y ☐ N

Please fax copy of insurance card with order.

Deductible $ _____ Met ☐ Y ☐ N OOP $ _____ Met ☐ Y ☐ N

OCSRI-NPI 1508172982

☐ Report only to office ☐ CD with report only to office ☐ Patient to hand-carry films

☐ HOLD AND CALL REPORT Call Report # _____ Fax Report # _____

CT

HEAD/NECK

w w/o
- ☐ ☐ Brain
- ☐ ☐ Sinuses
- ☐ ☐ Temporal Bones/IAC
- ☐ ☐ Orbits
- ☐ ☐ Facial Bones
- ☐ ☐ Neck Soft Tissue

CHEST

w w/o
- ☐ ☐ Chest
- ☐ CTA Chest for PE

SPINE

w w/o
- ☐ ☐ Cervical Spine
- ☐ ☐ Thoracic Spine
- ☐ ☐ Lumbar Spine

ABD/PELVIS

w w/o
- ☐ ☐ Abdomen & Pelvis
- ☐ Renal Stone (ABD/Pelvis w/o)
- ☐ ☐ Abdomen Only
- ☐ ☐ Pelvis Only
- ☐ Other _____
- ☐ CT Lung Screening (low dose) CPT 71250

NUCLEAR MEDICINE

BONE SCAN

- ☐ Whole Body
- ☐ Multiple Specific Area
  - ☐ 3-Phase ☐ SPECT
- ☐ Liver/Spleen Scan
- ☐ Hepatobiliary (HIDA)
  CCK Ejection Fraction:
  - ☐ w ☐ w/o
- ☐ Cardiac MUGA Scan
- ☐ Gallium Scan ☐ Indium WBC Scan
- ☐ Octreoscan
- ☐ Parathyroid Scan
- ☐ Thyroid Consultation
- ☐ Thyroid Uptake and Scan
- ☐ I-131 Whole Body Scan
- ☐ Renal Scan
  - ☐ Flow and Function
- ☐ Other _____

PET/CT

- ☐ Eyes to Thigh
- ☐ Whole Body
- ☐ PET Bone Scan
- ☐ PET Other (limited)

ULTRASOUND

- ☐ Gallbladder / Liver (RUQ)
- ☐ Abdomen Complete
- ☐ Renal / Kidney (incl. bladder)
- ☐ Pelvic (w/ Endovag if indicated)
- ☐ Endovaginal only
- ☐ Thyroid / Neck
- ☐ Thyroid / Biopsy
- ☐ Testicular / Scrotum (including doppler)
- ☐ Carotid Doppler
- ☐ Extremity: Venus Doppler
  - ☐ L ☐ R ☐ Upper ☐ Lower
- ☐ Other _____

MRI

HEAD/NECK

w w/o
- ☐ ☐ Brain
- ☐ ☐ Orbit/Face/Neck
- ☐ ☐ TMJ

SPINE

w w/o
- ☐ ☐ Cervical Spine
- ☐ ☐ Thoracic Spine
- ☐ ☐ Lumbar Spine
- ☐ ☐ Sacrum

BODY

w w/o
- ☐ ☐ Chest
- ☐ ☐ Abdomen ☐ MRCP
- ☐ ☐ Pelvis
- ☐ ☐ Extremity ☐ L ☐ R
  Area of interest _____
- ☐ ☐ Extremity Joint ☐ L ☐ R
  Area of interest _____
- ☐ Other _____

RADIOGRAPHY (PLAIN FILMS)

THORAX

- ☐ Chest PA and Lateral
- ☐ Decub Chest ☐ L ☐ R
- ☐ Ribs ☐ L ☐ R ☐ Bilat

ABDOMEN

- ☐ KUB
- ☐ Flat & Upright (Obstruct. Series)
- ☐ Acute Abd Series (include PA Chest)
- ☐ Decub Abdomen
  - ☐ L ☐ R ☐ Bilat

HEAD

- ☐ Facial Bones
- ☐ Sinus Limited (Waters view)
- ☐ Sinus

EXTREMITIES/PELVIS

- ☐ Fingers: Spec
- ☐ Hand ☐ L ☐ R
- ☐ Wrist ☐ L ☐ R
- ☐ Forearm ☐ L ☐ R
- ☐ Elbow ☐ L ☐ R
- ☐ Humerus ☐ L ☐ R
- ☐ AC Joints Bilat w/wo weights
- ☐ Clavicle ☐ L ☐ R
- ☐ Shoulder ☐ L ☐ R
- ☐ Toes: Spec _____
- ☐ Foot ☐ L ☐ R
- ☐ Calcaneous ☐ L ☐ R
- ☐ Ankle ☐ L ☐ R
- ☐ Tibia/Fibula ☐ L ☐ R
- ☐ Knee ☐ L ☐ R
- ☐ Standing Knee ☐ L ☐ R
- ☐ Femur ☐ L ☐ R
- ☐ Hip ☐ L
- ☐ Pelvis ☐ R
- ☐ Other _____

INTERVENTIONAL RADIOLOGY

(please send patient for INR — cannot be older than 2 weeks)

- ☐ Port placement
- ☐ Port removal
- ☐ PICC line
- ☐ 6 tube placement
- ☐ Pleurex catheter
- ☐ Thoracentesis
- ☐ Parecentesis
- ☐ Kypho/Vert Aug (spine)
- ☐ RFA spine
- ☐ Other: _____

Physician Signature _____ Physician Printed Name _____

Physician Address (if CD is to be mailed) _____

Physician Office Phone Number: _____