



Salt Lake Regional

MEDICAL CENTER

1050 East South Temple, Salt Lake City, Utah 84102

IMAGING SERVICES OUTPATIENT PHYSICIAN ORDERING FORM

Centralized Scheduling: 801.350.4451 phone 801.350.4303 fax Radiology Front Desk: 801.350.8296

URGENT (1 day) **ASAP (1 -3 Days)** **ROUTINE** **Patient will call to schedule**

DATE:	PATIENT NAME: (please print)		
DAYTIME PHONE:	EVENING PHONE:	OTHER PHONE:	
DOB:	SOCIAL SECURITY #:		SEX:
INSURED NAME:	INSURED SSN#	INSURED ID#:	
INSURANCE CARRIER #1:	INSURANCE CARRIER #2:	PRE-AUTH #:	
ORDERING PHYSICIAN: (please print)		PHYSICIAN PHONE #	
DIAGNOSIS:		DX CODE:	
PHYSICIAN SIGNATURE:		DATE:	

MRI: _____

- Metal or Implanted Devices _____ PT < 350 lbs
- Radiologist to determine need for contrast Without Contrast With & Without Contrast*

* For Contrast Exam Creatinine within 6 weeks if PT is 60 or older, diabetic, Hx Kidney dz, transplant or single kidney, uncontrolled hypertension, Hx liver dz or transplant.

* Contrast Allergy needs premedication

MRA: _____

CT: _____

- Radiologist to determine need for IV Contrast Include Patient Medication List for Contrast Studies
- With & Without IV Contrast (if needed)* With IV Contrast* Without IV Contrast
- IV With Oral Contrast

* Contrast Studies need Bun & Creatinine within 30 days if PT is 65 or older, Diabetic, Hx Kidney dz, transplant or single kidney, uncontrolled hypertension

* Contrast Allergy needs premedication

X-RAY _____

FLUORO/IVPS: _____

NUC MED _____

ULTRASOUND:

- Abdominal Complete (NPO 6-8 hrs) Abdominal Limited (NPO 6-8 hrs)
- Pelvic w/Transvaginal (full bladder needed) Pelvic (full bladder needed)
- Obstetrical Breast Scrotum Renal/Bladder (full bladder needed)
- Thyroid Carotid Other _____
- Extremity Doppler UPPER LOWER
- RIGHT LEFT BILATERAL

MAMMO: (prior films required): Diagnostic Stereotactic / RT / LT _____ #Sites

BONE DENSITY SCAN