



Scheduling: 962-7900  
 Fax To: (833)965-0104

Last Name:		First Name:		MI:
Birthdate:		SS #:		
Phone Number (Home):		(Work):		
Appointment Date:	Check in time:	Scan time:		

## PHYSICIAN ORDER FOR OUTPATIENT CT IMAGING

DIAGNOSIS/SYMPTOMS		CONTACT NUMBER FOR CRITICAL RESULT	FORM COMPLETED BY (PRINT NAME)
			<input type="checkbox"/> Page when results are available Fax results to:
DATE/TIME	ORDERING PHYSICIAN'S NAME	IDC-9 Code	<b>Order may be modified at the discretion of the Radiologist.</b> <input type="checkbox"/> Please notify physician if order is modified.
	PHYSICIAN'S SIGNATURE		

**NOTE: Please circle exam and choose:**       with       without

Head	Petrous bones	Abdomen: <i>Pancreatitis/ hepatic</i>	Abdomen/ Pelvis
Neck	Chest	Abdomen/ Pelvis: <i>Enterography</i>	Chest with/ Abdomen with & without/ Pelvis with
Orbits	Chest: Hi Resolution	Abdomen/ Pelvis: <i>Kidney stone</i>	<b>CT Angio</b>
Face/ facial bones	Cardiac Scoring	Abdomen/Pelvis: <i>Pancreatitis/ hepatic</i>	Head      Neck
Sinus	Abdomen	Abdomen/ Pelvis: <i>Crohn's protocol</i>	Chest <i>PE, Aorta, heart</i>

**Spine (without contrast)**

Cervical Spine

Thoracic Spine

Lumbar Spine

**Exremities**

with       without

Shoulder	R	L	Ankle	R	L
Hip	R	L	Foot	R	L
Knee	R	L	Femur	R	L
Patellar tracking	R	L	Pelvis		

Chest/  
Abdomen/ Pelvis      *AAA, dissection*

Abdomen/  
Pelvis      *AAA, dissection*

Lower extremity run offs

*Patients over age 60 will be required to have a BUN & creatinine drawn before receiving contrast*

**LAB ORDERS:      BUN CREATININE**

Other:

Electronic forms are available at  
 WesleyMC.com

Wesley Scheduling  
 8:30-5:00 M-F  
 962-7900

Physicians with questions regarding procedure may contact Radiologist:  
 Imaging Services  
 962-2900