WESLEY Medical Center

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

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

PHYSICIAN ORDER FOR DIAGNOSTIC IMAGING

DIAGNOSIS/SYMPTOMS	CONTACT NUMBER FOR CRITICAL RESULT	FORM COMPLETED BY (PRINT NAME)
		☐ *Page when results are available* — Fax results to:

DATE/TIME	ORDERING PHYSICIAN'S NAME	ICD-9 Code	**Order may be modified at the discretion of the Radiologist.**
	PHYSICIAN'S SIGNATURE		☐ Please notify physician if order is modified.

DIAGNOSTIC IMAGING

Note: Please circle the exam. *No appointment necessary for these routine xrays.*

Chest PA, Lat ☐	Cervical Spine ☐	☐ R L ☐ Hip	☐ R L ☐ Femur	☐ R L ☐ Lower leg
Sinus ☐	Thoracic Spine ☐	☐ R L ☐ Knee	☐ R L ☐ Shoulder	☐ R L ☐ Forearm
Abdomen ☐	Lumbar Spine ☐	☐ R L ☐ Ankle	☐ R L ☐ Humerus	☐ R L ☐ Wrist
Pelvis ☐		☐ R L ☐ Foot	☐ R L ☐ Elbow	☐ R L ☐ Hand

☐ **Esophagus**

☐ **Swallow study with speech**

☐ **Small bowel study**

☐ **DEXA**

Upper GI (Stomach)
Single ☐ *(Circle)*
Air contrast ☐

Myelogram
☐ Cervical
☐ Thoracic
☐ Lumbar

Pertinent Medical History:

Barium Enema (Colon)
Single contrast (Barium) ☐
Air Contrast ☐ *(Circle)*
Gastrografin ☐

☐ **Voiding Cystogram**

LAB ORDERS:

☐ **BUN Creatinine** ☐ **UA Culture & Sensitivity** ☐ **Serum Pregnancy Test**

Other: