

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_  
 Phone# \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_  
 History/Diagnosis: \_\_\_\_\_

Requested by (print): \_\_\_\_\_  
 Signature Physician/PA/NP: \_\_\_\_\_

CT SCAN	INTERVENTIONAL RADIOLOGY	MRA
<p><b>SPECIFY IV CONTRAST</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Sinuses <input type="checkbox"/> C-Spine</p> <p><input type="checkbox"/> Head <input type="checkbox"/> T-Spine</p> <p><input type="checkbox"/> Chest <input type="checkbox"/> L-Spine</p> <p><input type="checkbox"/> Abd <input type="checkbox"/> 3D Recons</p> <p><input type="checkbox"/> Pelvis <input type="checkbox"/> Extremities (specify) _____</p> <p><input type="checkbox"/> Renal Stone Screening</p> <p><input type="checkbox"/> Soft Tissue Neck</p> <p><input type="checkbox"/> Temporal Bone/ Middle Ear</p> <p><input type="checkbox"/> CTA Head <input type="checkbox"/> CTA Abdomen &amp; Pelvis</p> <p><input type="checkbox"/> CTA Neck <input type="checkbox"/> CTA Run Off</p> <p><input type="checkbox"/> CTA Chest (includes abdomen)</p>	<p><b>Call (540) 498-4219</b></p> <p><b>ULTRASOUND</b></p> <p><input type="checkbox"/> Abdominal (includes gallbladder) <input type="checkbox"/> OB/Transvag/PRN Biophysical Profile</p> <p><input type="checkbox"/> Aorta <input type="checkbox"/> Duplex/Carotid</p> <p><input type="checkbox"/> Urinary Tract Renal/Bladder <input type="checkbox"/> Venous Doppler: Lower or Upper extremity (specify) _____</p> <p><input type="checkbox"/> Scrotum</p> <p><input type="checkbox"/> Thyroid/Parathyroid</p> <p><input type="checkbox"/> Pelvic/Transvaginal/PRN</p> <p><input type="checkbox"/> Other _____</p> <p><b>■ iSTAT Serum Creatinine</b></p>	<p><input type="checkbox"/> Brain</p> <p><input type="checkbox"/> Neck</p> <p><input type="checkbox"/> Abdominal ATTN: _____</p> <p><input type="checkbox"/> Renal Artery with only</p> <p><input type="checkbox"/> Chest</p> <p><b>OTHER</b></p> <p>Exam _____ Please specify body area and if contrast is desired.</p> <p><b>MRI PELVIS</b></p> <p><b>SPECIFY</b> <input type="checkbox"/> W/O <b>OR</b> <input type="checkbox"/> W/WO</p> <p><input type="checkbox"/> Bony Pelvis</p> <p><input type="checkbox"/> Uterine</p> <p><input type="checkbox"/> Ovarian</p> <p><b>UROLOGICAL</b></p> <p><input type="checkbox"/> IVP</p> <p>See CT Scanning and Ultrasound for other renal imaging exams</p>
CT SCREENINGS	MRI NEURO	GASTROINTESTINAL TRACT
<p><input type="checkbox"/> HeartScan</p>	<p><b>SPECIFY</b> <input type="checkbox"/> W/O <b>OR</b> <input type="checkbox"/> W/WO</p> <p><input type="checkbox"/> Brain Attn: _____</p> <p><input type="checkbox"/> Cervical</p> <p><input type="checkbox"/> Thoracic</p> <p><input type="checkbox"/> Lumbar</p>	<p><input type="checkbox"/> Barium Enema <input type="checkbox"/> Small Bowel</p> <p><input type="checkbox"/> Esophagram <input type="checkbox"/> UGI</p>
BREAST IMAGING	MRI EXTREM	DIAGNOSTIC (PLAIN FILMS)
<p><input type="checkbox"/> Screening Mammography (asymptomatic)</p> <p><input type="checkbox"/> Diagnostic Mammography</p> <p><input type="checkbox"/> Breast Sonography <input type="checkbox"/> Cyst Aspiration</p> <p><input type="checkbox"/> Core Biopsy <input type="checkbox"/> Stereotactic <input type="checkbox"/> Ultrasound Guided</p> <p><input type="checkbox"/> MRI Breast</p> <p><input type="checkbox"/> Bilateral</p> <p><input type="checkbox"/> Unilateral <input type="checkbox"/> Left <input type="checkbox"/> Right</p> <p><input type="checkbox"/> MRI Breast Biopsy</p> <p><input type="checkbox"/> Mammo Consult</p>	<p><b>SPECIFY</b> <input type="checkbox"/> W/O <b>OR</b> <input type="checkbox"/> W/WO</p> <p><input type="checkbox"/> Arthrogram _____ <input type="checkbox"/> Right <input type="checkbox"/> Left</p> <p><input type="checkbox"/> Exam _____ <input type="checkbox"/> Right <input type="checkbox"/> Left</p>	<p><input type="checkbox"/> Abdomen <input type="checkbox"/> Spine</p> <p><input type="checkbox"/> Flat <input type="checkbox"/> Cervical <input type="checkbox"/> Lumbar</p> <p><input type="checkbox"/> Flat &amp; Erect <input type="checkbox"/> Thoracic</p> <p><input type="checkbox"/> Chest <input type="checkbox"/> Sinuses</p> <p><input type="checkbox"/> PA &amp; LAT <input type="checkbox"/> Extremities</p> <p><input type="checkbox"/> PA Only <input type="checkbox"/> Hand __L__R</p> <p><input type="checkbox"/> Ribs __L__R <input type="checkbox"/> Wrist __L__R</p> <p><input type="checkbox"/> Metastatic <input type="checkbox"/> Knee __L__R</p> <p><input type="checkbox"/> Bone Survey <input type="checkbox"/> Shoulder __L__R</p> <p><input type="checkbox"/> AP Pelvis <input type="checkbox"/> Ankle __L__R</p> <p><input type="checkbox"/> Rt. Hip w/ Pelvis <input type="checkbox"/> Foot __L__R</p> <p><input type="checkbox"/> Lt. Hip w/ Pelvis</p> <p><input type="checkbox"/> Other (specify) _____</p>
NUCLEAR MEDICINE	MRI ABD	
<p><input type="checkbox"/> Bone Scan <input type="checkbox"/> Whole Body <input type="checkbox"/> Three Phase <input type="checkbox"/> Limited</p> <p><input type="checkbox"/> Thyroid Scan and Uptake <input type="checkbox"/> ParaThyroid <input type="checkbox"/> HIDA <input type="checkbox"/> Gastric Emptying</p> <p><input type="checkbox"/> Renal Scan <input type="checkbox"/> w/ lasix <input type="checkbox"/> w/ captopril</p> <p><input type="checkbox"/> Cardiac Stress Test <input type="checkbox"/> Exercise <input type="checkbox"/> Lexiscan <input type="checkbox"/> Dobutamine</p>	<p><b>SPECIFY</b> <input type="checkbox"/> W/O <b>OR</b> <input type="checkbox"/> W/WO</p> <p><b>ATTN:</b> _____</p>	

Patient Information/Label

## Radiology Orders



**Fax Number: 1-888-310-4618**



# Spotsylvania Regional Medical Center

*HCA Virginia Health System*



From I-95, take exit 126 (from north) or exit 126-B (from south) to Route 1 south. Follow Route 1 south approximately 1.2 miles to Spotsylvania Parkway. Turn left (east) onto Spotsylvania Parkway and follow approximately ½ mile over the bridge to Spotsylvania Regional Medical Center on the right.

Patient Information/Label