McLaren
NORTHERN MICHIGAN

McLaren Northern Michigan X-Ray Order Form

Patient's Name Last: First: MI:		**Date of Birth**	**Today's Date**
Is there any chance that the patient is pregnant? Y ☐ N ☐	**Exam Date** **Time**	☐ Cheboygan ☐ Petoskey ☐ Gaylord	
Patient Phone:			

Ordered by: _____ _____

Provider's Printed Name **Ordering Provider's Signature**

Signs and Symptoms / Diagnosis / Reason for Exam / Underlying Medical Conditions / Chronic Conditions / Documented Clinical Findings relevant to imaging study being ordered: _____

_____ ***ICD-10 Code(s):*** _____

CHEST	UPPER EXTREMITY	LOWER EXTREMITY	SPINE
☐ Chest 2v (PA & lat)	☐ Finger(s) 1 2 3 4 5 L☐ R☐	☐ Toe(s) 1 2 3 4 5 L☐ R☐	☐ Cervical AP & Lat (Min. 4 views if Swimmers/Fuchs view is needed to see C-1 / C-7)
☐ Chest 1v (AP or PA)	☐ Hand L☐ R☐	☐ Foot L☐ R☐	
☐ Chest 2v w/ Apical Lordotic	☐ Bone Age L☐ R☐	☐ Calcaneus (Heel) L☐ R☐	☐ Cervical AP & Lat Only (post-op)
☐ Chest 4v (PA & lat w/obliques)	☐ Wrist L☐ R☐	☐ Ankle Survey (2 views) L☐ R☐	☐ Cervical AP & Lat w Obliques
☐ Chest Insp & Exp w Lateral	☐ Wrist with Scaphoid View L☐ R☐	☐ Ankle Complete (4 views) L☐ R☐	☐ Cervical Comp (w obl, flex & ext)
☐ Ribs Right w PA Chest	☐ Forearm L☐ R☐	☐ Tib-Fib L☐ R☐	☐ Thoracic w Swimmers View
☐ Ribs Left w PA Chest	☐ Elbow Survey (AP & lat) L☐ R☐	☐ Knee Survey (AP & lat only) L☐ R☐	☐ Thoraco-Lumbar Spine
☐ Ribs Bilateral w PA Chest	☐ Elbow Trauma (4 views) L☐ R☐	☐ Knee 3 Views L☐ R☐	☐ Lumbar AP & Lat Only (post-op)
☐ Decubitus Chest L☐ R☐	☐ Humerus L☐ R☐	☐ Knee Complete (4 views) L☐ R☐	☐ Lumbar Lateral (Flex & Ext Only)
☐ Sternum	☐ Shoulder L☐ R☐	☐ Femur L☐ R☐	☐ Lumbar Min. 4 Views (includes AP, AP sacrum, lat. & spot)
ABDOMEN	☐ Scapula L☐ R☐	☐ Hip Complete L☐ R☐	☐ Lumbar AP & Lat w Obliques
☐ AP Single View (KUB)	☐ Clavicle L☐ R☐	☐ Pelvis	☐ Lumbar Complete w Obliques and Flex & Ext
☐ AP & Upright/Decubitus	☐ AC Joints	☐ SI Joints	☐ Sacrum/Coccyx
☐ Acute Abd w 1v Chest	☐ Infant Upper (Under 18 mos.) L☐ R☐	☐ Infant Lower (Under 18 mos) L☐ R☐	☐ Neck Soft Tissue AP & Lat
☐ VP Shunt Evaluation	☐ Other (Specify in free text box)	☐ Other (Specify in free text box)	☐ Other (Specify in free text box)
☐ Babygram		**To be Scheduled: Please Call 231.487.3100**	
☐ Other (Specify in free text box)	**HEAD**	☐ Scoliosis Standing	☐ Leg Length L☐ R☐
Free Text Box: (include any special instructions)		☐ Cystogram	☐ Bone Survey Complete
	☐ Skull Complete	☐ Voiding Cystogram (VCUG)	☐ T-Tube Injection
	☐ Skull PA & Lateral	☐ Hysterosalpingogram	☐ Sniff Test
	☐ Skull for Pressure Valve Check	☐ IVP w Tomograms	Arthrogram No CT/MRI
	☐ Facial Bones Complete	☐ Nephrostogram	☐ Shoulder ☐ Wrist L☐ R☐
	☐ Mandible	☐ Hip Injection L☐ R☐ (please specify medications in free text box)	☐ Barium Enema Single Contrast
	☐ Orthopantogram (Panorex)		
	☐ Nasal Bones	☐ Lumbar Puncture Under Fluoro	☐ Barium Enema Air Contrast
	☐ Orbits / Pre MRI / Foreign Body	☐ Cervical Myelogram w CT	☐ Water Soluble Enema
	☐ Orbits Trauma	☐ Thoracic Myelogram w CT	☐ Enema via Colostomy
	☐ Sinuses – Waters View Only	☐ Lumbar Myelogram w CT	☐ Esophagram (Barium Swallow)
	☐ Sinuses Complete	☐ Therapeutic Spinal Injection Procedure	☐ Small Bowel Series
	☐ Other (Specify in free text box)	In "Free Text Box", please indicate type of injection, laterality, levels or other important clinical information. Consultation with Radiologist recommended.	☐ Upper GI Air Contrast (Routine)
			☐ Upper GI Single Contrast
		☐ RFN (Please specify levels in free text)	☐ Video Swallow
		☐ TMJ X-Ray with tomography	☐ Other (Specify in free text box)

Please Complete/Print/Sign and Fax to Central Scheduling: Fax 231.487.7920 Tel 231.487.3100 Toll Free 866.487.3100