PIH HEALTH

OUTPATIENT RADIOLOGY
CT ORDERS

12401 Washington Blvd.
Whittier, CA 90602

P: 562.698.0811
TDD: 562.696.9267

ACT: MR:

DOB:
ADM: RM:

Location ☐ **Whittier** ☐ **Downey**

Patient Name _____ DOB _____ Age _____

Patient Contact Number # _____

Reason for Exam _____
(Indications, Symptoms, Relevant Clinical History)

☐ eMD Record Available ☐ Recent Progress Notes Attached

ALLERGIES ☐ Contrast ☐ No Known Allergies ☐ Other _____

CONTRAST Must select one of the following ☐ **Requesting Radiology Consult – Need order clarification**

☐ With **OR** Without Intravenous Contrast per Radiology Protocol
☐ With Intravenous Contrast
☐ No Intravenous Contrast
☐ With **AND** Without Intravenous Contrast

Please Order Serum Creatinine prior to any contrast exam for patients who are over 60 years of age, have a history of, or are diagnosed with diabetes, renal insufficiency, hypertension, and severe hepatic disease or liver transplant (post or pending).

CT Head/Neck/Chest/Abdomen/Pelvis/Extremity

☐ CT Head ☐ CT Orbits ☐ CT Sinus ☐ CT Facial Bones
☐ CT Temporal Bones ☐ CT Neck ☐ CT Chest Hi Resolution ☐ CT Chest
☐ CT Abdomen ***and*** Pelvis ☐ CT Abdomen ***Only*** ☐ CT Pelvis ***Only***
☐ CT Urogram (oral contrast not required) ☐ CT Enterography

CT Spine - REQUIRES AUTHORIZATION

☐ CT Cervical Spine ☐ CT Thoracic Spine ☐ CT Lumbar Spine
☐ CT Right Lower Extremity ☐ CT Left Lower Extremity Specify Body Part _____
☐ CT Right Upper Extremity ☐ CT Left Upper Extremity Specify Body Part _____
☐ Myelogram with CT to follow (authorization not required) Specify Area _____

CT Angiogram/Cardiac

☐ CTA Head ☐ CTA Neck ☐ CTA Chest for Pulmonary Embolus
☐ CTA Chest Gated for Aorta ☐ CTA Chest for EP Ablation ☐ CTA Coronary Artery with Calcium Evaluation
☐ CT Heart ☐ CT Heart Calcium Scoring ***Only*** *(non-contrast)*
☐ CTA Abdomen ***and*** Pelvis ☐ CTA Abdomen ***Only*** ☐ CTA Pelvis ***Only***
☐ CTA Lower Extremity ☐ Right ☐ Left ☐ CTA Upper Extremity ☐ Right ☐ Left
☐ CTA Run-Off (includes abdomen, pelvis and lower extremity)

CT Guided Invasive Procedures

☐ CT Biopsy (specify body part) _____
☐ CT Percutaneous Abscess Drain with Catheter ☐ Right ☐ Left

CT Other

☐ (please specify) _____

LABORATORY

☐ Ordered ☐ Resulted and Faxed to Scheduling

EXAM COMPLETION PRIORITY

☐ Routine (completed as schedule allows)
☐ Urgent (completed within 2 days)
☐ STAT (exam completed today)

STAT Exams
☐ Call Clinician/Office with results and hold patient until direction is given
☐ Fax results and send patient back to office

_____ _____ _____ _____
Time Date Physician Signature Physician Name (Please Print)

Alternate Office Contact Name _____ Number _____

Radiology Scheduling Direct Phone Number 562.906.5572 *Radiology Scheduling Fax 562.464.5018*