



ORDERS • DIAGNOSTIC IMAGING

Medical Record Number

Patient Name

Minimum of two (2) forms of ID required

Current LPCH Label – Patient Name, Medical Record Number

APPOINTMENT SCHEDULED FOR: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_  
(Radiology Use ONLY)

Scheduling phone: (650) 497-8376 Scheduling Fax for CT/MR and all other orders: (650) 724-2663

CT\*  Fluoroscopy\*  MRI\*  Ultrasound  X-ray (skip to section A)

Best time and way to reach patient/family: (one required) Home # \_\_\_\_\_ Time: \_\_\_\_\_  
Cell Phone # \_\_\_\_\_ Name: \_\_\_\_\_ Time: \_\_\_\_\_  
Work Phone # \_\_\_\_\_ Name: \_\_\_\_\_ Time: \_\_\_\_\_

Check one:  Schedule directly with patient  Schedule with Clinic Staff who will confirm with patient  
(Include name/phone)

Are there any special needs we need to know about (i.e. translator?)  Yes  No

Specify any special scheduling information: \_\_\_\_\_

<b>SECTION A:</b>
<b>Exam requested:</b> _____
<b>ICD-9 code(s):</b> _____ <b>Symptoms:</b> _____ (required) (Do not use Rule out or Follow up)
<b>Clinical Concern:</b> _____
<b>Underlying/Provisional Diagnosis</b> _____

\*Required for CT, MRI or Fluoroscopy. History and Physical suggested, required for all non LPCH referrals

- |  |  |  |
|--|--|--|
| 1. Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes                                      | 8. History of Contrast reaction <input type="checkbox"/> No <input type="checkbox"/> Yes | 14. Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes          |
| 2. Adverse sedation event <input type="checkbox"/> No <input type="checkbox"/> Yes                         | 9. Development delay <input type="checkbox"/> No <input type="checkbox"/> Yes            | 15. History of Cancer <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 3. CNS abnormalities <input type="checkbox"/> No <input type="checkbox"/> Yes                              | 10. Renal Disease <input type="checkbox"/> No <input type="checkbox"/> Yes               | 16. Sickle Cell <input type="checkbox"/> No <input type="checkbox"/> Yes       |
| 4. Apnea/Snoring <input type="checkbox"/> No <input type="checkbox"/> Yes                                  | 11. History of Transplant <input type="checkbox"/> No <input type="checkbox"/> Yes       | 17. Previous MRI <input type="checkbox"/> No <input type="checkbox"/> Yes      |
| 5. Other airway issue <input type="checkbox"/> No <input type="checkbox"/> Yes                             | 12. Hepatic Disease <input type="checkbox"/> No <input type="checkbox"/> Yes             | 18. Previous CT <input type="checkbox"/> No <input type="checkbox"/> Yes       |
| 6. Lung Disease/Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes                            | 13. Vomiting/Reflux <input type="checkbox"/> No <input type="checkbox"/> Yes             |  |
| 7. Female greater than 12 years of age (Pregnant) <input type="checkbox"/> No <input type="checkbox"/> Yes |  |  |

All "YES" responses require comments/details: \_\_\_\_\_

Primary Insurance Carrier: \_\_\_\_\_ Secondary Insurance Carrier: \_\_\_\_\_

OR Current LPCH Label

ID# \_\_\_\_\_ ID# \_\_\_\_\_

Insurance Phone # \_\_\_\_\_ Insurance Phone # \_\_\_\_\_

Send a copy (front and back) of insurance card if possible

Referring Location: \_\_\_\_\_ or \_\_\_\_\_ and \_\_\_\_\_  
LPCH Clinic Office Phone Number FAX

Ordering \_\_\_\_\_  
Print Name Signature Date Pager

Attending/PCP: \_\_\_\_\_  
Print Name Signature Date Pager