External Provider UNCH Outpatient Radiology Order Form

Clinic Name: ______________________________________
Ordering Provider Name: ______________________________
Please PRINT Provider Name (signature line is in grey box below)
Clinic Contact: _____________________________________
Phone: _____________________________________________

CT Scan Scheduling Questions: If yes to any of the answers please inform Radiology scheduler.

YES NO 1. Has the patient had an allergic reaction to IV contrast?

YES NO 2. Is the patient on any medication containing metformin? (Glucophage)

YES NO 3. Does the patient have a history of diabetes, renal disease, multiple myeloma, lupus or scleroderma?

YES NO 4. Is the patient on IV antibiotics?

YES NO 5. Is the patient taking daily doses of NSAIDs (Advil, Aleve, Celebrex, Lodine, etc)?

YES NO 6. Does the patient have a recent (within 3 months) serum creatinine value? If yes, when?

YES NO 7. Pregnancy?_____________________  Date of LMP:___________________

MRI Scheduling Questions: If yes to any of the answers please inform Radiology scheduler.

YES NO 1. Has the patient ever had a cardiac pacemaker, defibrillator, or LifeVest?

YES NO 2. Has the patient had an aneurysm repair? Does the patient have an aneurysm clip(s)?

YES NO 3. Does the patient have an artificial heart valve?

YES NO 4. Does the patient have any mechanical devices, pumps, stents, implants (neurostimulators, cochlear, etc.)?

YES NO 5. Has the patient ever had an eye injury involving metal or been injured by a metallic foreign body? Has the patient ever done any grinding or welding?

YES NO 6. Has the patient had an allergic reaction to IV contrast?

YES NO 7. Pregnancy?_____________________  Date of LMP:___________________