

**Berkeley Outpatient Center Imaging**  
 3100 San Pablo Ave, 3rd Floor, Berkeley CA 94702  
 Scheduling: 510.985.5030 • Fax: 415.353.7299

Creatinine: \_\_\_\_\_ Date: \_\_\_\_\_  
 Pregnancy:  Yes  No  
 Prior Contrast Reaction:  Yes  No  
 Impaired Renal Function:  Yes  No

PATIENT APPOINTMENT	
Date:	_____
Time:	_____
Location:	_____
STAT REQUEST:	<input type="checkbox"/> Yes <input type="checkbox"/> No

**BERKELEY OUTPATIENT CENTER IMAGING ORDER FORM**

**Patient Information:**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ UCSF MRN (if available): \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Referring Physician Information:**

Physician Name: \_\_\_\_\_ Office Contact Person: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Diagnosis/Clinical Indications:** \_\_\_\_\_

**MD Signature Required:** \_\_\_\_\_

**Exam Requested:** *Please check box carefully for requested study and complete required sections below.*

<input type="checkbox"/> MRI	<input type="checkbox"/> CT	<input type="checkbox"/> X-Ray		<input type="checkbox"/> DEXA
<input type="checkbox"/> Contrast <input type="checkbox"/> Yes <input type="checkbox"/> No <b>MR Neuroradiology &amp; ENT</b> <input type="checkbox"/> Brain <input type="checkbox"/> Brain Lab <input type="checkbox"/> w/fiducials <input type="checkbox"/> w/o fiducials <input type="checkbox"/> Nasopharynx (w/Neck) <input type="checkbox"/> Stereotactic Brain <input type="checkbox"/> Stealth Brain <input type="checkbox"/> Internal Auditory Canal <input type="checkbox"/> Pituitary <input type="checkbox"/> TMJ <input type="checkbox"/> Orbits <input type="checkbox"/> Sinus <b>MR Spine</b> <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Total Spine <input type="checkbox"/> Neurogram <b>MR Vascular</b> <input type="checkbox"/> Intracranial MRA <input type="checkbox"/> Cervical Carotids/ Neck MRA <b>MR Body</b> <input type="checkbox"/> Full Body <input type="checkbox"/> Abdomen <input type="checkbox"/> Pancreas <input type="checkbox"/> Liver <input type="checkbox"/> Pelvis <input type="checkbox"/> Breast <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Mass <input type="checkbox"/> Leak <input type="checkbox"/> TMJ <input type="checkbox"/> Prostate	<input type="checkbox"/> Contrast <input type="checkbox"/> Yes <input type="checkbox"/> No <b>CT Neuroradiology &amp; ENT</b> <input type="checkbox"/> Brain <input type="checkbox"/> Orbits <input type="checkbox"/> Temporal Bone <input type="checkbox"/> Neck <input type="checkbox"/> Maxillofacial <input type="checkbox"/> Sinus <input type="checkbox"/> CT Angiogram <input type="checkbox"/> SAH <input type="checkbox"/> Stroke <b>CT Spine</b> <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <b>CT Body</b> <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> CTA Abd/Pel <input type="checkbox"/> Renal Donor <input type="checkbox"/> Liver Donor <b>CT Miscellaneous</b> <input type="checkbox"/> Bilateral lower extremity runoff	<b>X-Ray Thorax</b> <input type="checkbox"/> Chest 2 Views <input type="checkbox"/> Ribs <input type="checkbox"/> Sternum <input type="checkbox"/> Clavicle <input type="checkbox"/> Sterno-clavicular Joints <input type="checkbox"/> AC Joints <input type="checkbox"/> Abdomen <b>X-Ray Spine</b> <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Thoracolumbar Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Sacrum/Coccyx <input type="checkbox"/> Scoliosis Series <input type="checkbox"/> Pelvis <b>X-Ray Lower Extremity</b> <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilat <input type="checkbox"/> Hip <input type="checkbox"/> Femur <input type="checkbox"/> Knee <input type="checkbox"/> Tibia/Fibula <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> Heel <input type="checkbox"/> Toe <input type="checkbox"/> Hip-to-Ankle	<b>X-Ray Upper Extremity</b> <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilat <input type="checkbox"/> Shoulder <input type="checkbox"/> Humerus <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Finger <b>X-Ray Head</b> <input type="checkbox"/> Skull <input type="checkbox"/> Facial Bones <input type="checkbox"/> Nasal Bones <input type="checkbox"/> Orbits <input type="checkbox"/> Mandible <b>X-Ray Misc. Exams</b> <input type="checkbox"/> Bone Survey <input type="checkbox"/> Myeloma <input type="checkbox"/> Metabolic <input type="checkbox"/> Pediatric <input type="checkbox"/> Bone Age <input type="checkbox"/> Shunt Series <input type="checkbox"/> Other: _____	<input type="checkbox"/> DEXA Bone Density Scan <b>ULTRASOUND</b> <b>US Abdomen</b> <input type="checkbox"/> Abdomen complete <input type="checkbox"/> Abdomen w/Doppler <input type="checkbox"/> Pre-Liver Transplant <input type="checkbox"/> Post-Liver Transplant <input type="checkbox"/> Renal/Bladder only <input type="checkbox"/> Kidney Transplant <b>US OB/GYN</b> <input type="checkbox"/> Pelvis (Uterus & Ovaries) <input type="checkbox"/> Pelvis w/transvaginal imaging <input type="checkbox"/> First Trimester OB <input type="checkbox"/> singleton <b>US Superficial Structures</b> <input type="checkbox"/> Thyroid/Parathyroid <input type="checkbox"/> Scrotum <b>US Vascular</b> <input type="checkbox"/> Venous (DVT): Upper Extremity <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilat <b>US Miscellaneous</b> <input type="checkbox"/> Soft tissue-give location: _____ <input type="checkbox"/> Other: _____
<input type="checkbox"/> PET/CT				
<b>Please specify one:</b> <input type="checkbox"/> Initial Treatment Strategy <input type="checkbox"/> Subsequent Treatment Strategy <input type="checkbox"/> PETCT FDG VERTEX TO MID THIGH (NON-DIAGNOSTIC CT) - If no additional CT is required. <input type="checkbox"/> PETCT FDG VERTEX TO TOES (NON-DIAGNOSTIC CT) - If no additional CT is required. <input type="checkbox"/> PETCT Vertex to Mid-Thigh – If additional Diagnostic CTs are needed: <input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Abd/Pelvis <input type="checkbox"/> Lower Extremities <input type="checkbox"/> Upper Extremities   <input type="checkbox"/> With Contrast <input type="checkbox"/> Without Contrast <input type="checkbox"/> PETCT Vertex to Toes – If additional Diagnostic CTs are needed: <input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Abd/Pelvis <input type="checkbox"/> Lower Extremities <input type="checkbox"/> Upper Extremities   <input type="checkbox"/> With Contrast <input type="checkbox"/> Without Contrast (CT without IV contrast because of medical contraindication to IV contrast)				