

# Imaging Order Form



## Berkeley Outpatient Center

3100 San Pablo Ave., Suite 330  
Berkeley, CA 94702

**Scheduling:** (510) 985-5030  
**Fax:** (415) 353-7299

Notes: \_\_\_\_\_  
\_\_\_\_\_

### Patient Information:

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 for requested study and complete required sections below.

### STAT Request:

Yes  No

<input type="checkbox"/> MRI	<input type="checkbox"/> CT	<input type="checkbox"/> X-Ray		<input type="checkbox"/> Ultrasound
<p>Contrast: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>MR Neuroradiology &amp; ENT</b></p> <p><input type="checkbox"/> Brain <input type="checkbox"/> Nasopharynx (w/neck) <input type="checkbox"/> Internal auditory canal <input type="checkbox"/> Pituitary <input type="checkbox"/> TMJ <input type="checkbox"/> Orbits <input type="checkbox"/> Sinus</p> <p><b>MR Spine</b></p> <p><input type="checkbox"/> Cervical spine <input type="checkbox"/> Thoracic spine <input type="checkbox"/> Lumbar spine <input type="checkbox"/> Total spine <input type="checkbox"/> Neurogram</p> <p><b>MR Vascular</b></p> <p><input type="checkbox"/> Intracranial MRA <input type="checkbox"/> Cervical carotids / neck MRA</p> <p><b>MR Body</b></p> <p><input type="checkbox"/> Full body <input type="checkbox"/> Abdomen <input type="checkbox"/> Pancreas <input type="checkbox"/> Liver <input type="checkbox"/> Pelvis <input type="checkbox"/> TMJ <input type="checkbox"/> Prostate</p> <p><b>Chest/Cardiac</b></p> <p><input type="checkbox"/> Chest <input type="checkbox"/> Thyroid <input type="checkbox"/> Parathyroid <input type="checkbox"/> Cardiac MRI</p> <p><b>MR Body MRA</b></p> <p><input type="checkbox"/> MRA abdomen <input type="checkbox"/> MRA thoracic <input type="checkbox"/> Renal MRA <input type="checkbox"/> Lower extremity w/ runoff <input type="checkbox"/> Other: _____</p> <p><b>MR Musculoskeletal</b></p> <p><input type="checkbox"/> Right <input type="checkbox"/> Left</p> <p><input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Finger <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Foot</p>	<p>Contrast: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>CT Neuroradiology &amp; ENT</b></p> <p><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</p> <p><b>CT Spine</b></p> <p><input type="checkbox"/> Cervical spine <input type="checkbox"/> Thoracic spine <input type="checkbox"/> Lumbar spine</p> <p><b>CT Body</b></p> <p><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</p> <p><b>CT Miscellaneous</b></p> <p><input type="checkbox"/> Bilateral lower extremity runoff</p>	<p><b>X-Ray Thorax</b></p> <p><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</p> <p><b>X-Ray Spine</b></p> <p><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</p> <p><b>X-Ray Lower Extremity</b></p> <p><input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilat</p> <p><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</p>	<p><b>X-Ray Upper Extremity</b></p> <p><input type="checkbox"/> Right <input type="checkbox"/> Left</p> <p><input type="checkbox"/> Bilat</p> <p><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</p> <p><b>X-Ray Head</b></p> <p><input type="checkbox"/> Skull <input type="checkbox"/> Facial bones <input type="checkbox"/> Nasal bones <input type="checkbox"/> Orbits <input type="checkbox"/> Mandible</p> <p><b>X-Ray Misc. Exams</b></p> <p><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: _____</p>	<p><b>US Abdomen</b></p> <p><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</p> <p><b>US OB/GYN</b></p> <p><input type="checkbox"/> Pelvis (uterus &amp; ovaries) <input type="checkbox"/> Pelvis w/ transvaginal imaging <input type="checkbox"/> First trimester OB <input type="checkbox"/> Singleton</p> <p><b>US Superficial Structures</b></p> <p><input type="checkbox"/> Thyroid/parathyroid <input type="checkbox"/> Scrotum</p> <p><b>US Vascular</b></p> <p><input type="checkbox"/> Venous (DVT): upper extremity <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilat</p> <p><b>US Miscellaneous</b></p> <p><input type="checkbox"/> Soft tissue-give location: _____ <input type="checkbox"/> Other: _____</p>
<p><input type="checkbox"/> DEXA</p> <p><input type="checkbox"/> DEXA bone density scan <input type="checkbox"/> Spine/hip <input type="checkbox"/> Spine/hip w/ TBS <input type="checkbox"/> Forearm (only order if patient had spinal surgery or bilateral hip replacement) <input type="checkbox"/> Vertebral FX assessment (VFA)</p>	<p><input type="checkbox"/> PET/CT</p> <p><b>Please specify one:</b></p> <p><input type="checkbox"/> Initial treatment strategy <input type="checkbox"/> Subsequent treatment strategy</p> <p><input type="checkbox"/> PETCT FDG Vertex to mid-thigh (Non-diagnostic CT) – If no additional CT is required.</p> <p><input type="checkbox"/> PETCT FDG Vertex to mid-toes (Non-diagnostic CT) – If no additional CT is required.</p> <p><input type="checkbox"/> PETCT Vertex to mid-thigh – If any of the following additional diagnostic CTs are needed: <input type="checkbox"/> neck <input type="checkbox"/> chest <input type="checkbox"/> abd/pelvis <input type="checkbox"/> lower ext <input type="checkbox"/> upper ext   <input type="checkbox"/> w/ contrast <input type="checkbox"/> w/o contrast</p> <p><input type="checkbox"/> PETCT Vertex to toes – If any of the following additional diagnostic CTs are needed: <input type="checkbox"/> neck <input type="checkbox"/> chest <input type="checkbox"/> abd/pelvis <input type="checkbox"/> lower ext <input type="checkbox"/> upper ext   <input type="checkbox"/> w/ contrast <input type="checkbox"/> w/o contrast (CT without IV contrast because of medical contraindication to IV contrast)</p>			

**Please note:** If your patient requires anesthesia, please call (415) 353-7900 to schedule at the UCSF Mission Bay or Parnassus locations.