



Physician Order for Outpatient Services
2598 W. White River Blvd. • Muncie, IN 47304
Scheduling (765) 282-7595 • Fax (765) 288-0737

Patient Name: _____

D.O.B. ____/____/____ Diagnosis: _____

Test Date: _____ Time of Exam: _____

Fax report to: _____

Is there a chance that the patient may be pregnant? (yes) ____ (no) ____

X _____
 Physician Signature Date Time

MRI EXAMS
BRAIN <input type="checkbox"/>
BREAST <input type="checkbox"/>
SOFT TISSUE NECK <input type="checkbox"/>
INTERNAL AUDITORY CANALS <input type="checkbox"/>
ORBITS <input type="checkbox"/>
PITUITARY GLANDS <input type="checkbox"/>
SPINE <input type="checkbox"/> CERVICAL <input type="checkbox"/> THORACIC <input type="checkbox"/> LUMBAR
BRACHIAL PLEXUS <input type="checkbox"/>
UPPER EXTREMITY <input type="checkbox"/> R <input type="checkbox"/> L
LOWER EXTREMITY <input type="checkbox"/> R <input type="checkbox"/> L
PELVIS/HIP <input type="checkbox"/> R <input type="checkbox"/> L
SHOULDER <input type="checkbox"/> R <input type="checkbox"/> L
KNEE <input type="checkbox"/> R <input type="checkbox"/> L
ELBOW <input type="checkbox"/> R <input type="checkbox"/> L
WRIST <input type="checkbox"/> R <input type="checkbox"/> L
HAND/FINGER <input type="checkbox"/> R <input type="checkbox"/> L
ANKLE <input type="checkbox"/> R <input type="checkbox"/> L
FOOT <input type="checkbox"/> R <input type="checkbox"/> L
MRCP (WILL NEED PREP) <input type="checkbox"/>
ABDOMEN <input type="checkbox"/>
LIVER <input type="checkbox"/>
ADRENAL <input type="checkbox"/>
KIDNEY <input type="checkbox"/>
PELVIS <input type="checkbox"/>
UTERUS <input type="checkbox"/>
MRA BRAIN <input type="checkbox"/>
MRA RENALS <input type="checkbox"/>
MRA CAROTID/NECK <input type="checkbox"/>

CT EXAMS
BRAIN <input type="checkbox"/>
SINUSES <input type="checkbox"/>
TEMPORAL BONES <input type="checkbox"/>
FACIAL BONES <input type="checkbox"/>
ORBITS <input type="checkbox"/> SELLA <input type="checkbox"/> EAR <input type="checkbox"/> IAC' S <input type="checkbox"/>
SOFT TISSUE NECK <input type="checkbox"/>
LUMBAR <input type="checkbox"/>
CERVICAL <input type="checkbox"/>
THORACIC <input type="checkbox"/>
CHEST <input type="checkbox"/>
<input type="checkbox"/> ROUTINE <input type="checkbox"/> PULM. EMBOLISM <input type="checkbox"/> INTERSTITIAL DISEASE
ABDOMEN & PELVIS <input type="checkbox"/>
ROUTINE (INCLUDES APPENDICITIS PROTOCOL)
UROGRAM <input type="checkbox"/>
RENAL STONE PROTOCOL <input type="checkbox"/>
ABDOMEN <input type="checkbox"/> ROUTINE <input type="checkbox"/> LIVER <input type="checkbox"/> PANCREAS <input type="checkbox"/> KIDNEY (CYST/MASS) <input type="checkbox"/> ADRENALS
PELVIS <input type="checkbox"/>
MUSCULOSKELETAL <input type="checkbox"/>
UPPER EXTREMITY <input type="checkbox"/> R <input type="checkbox"/> L
BODY PART
LOWER EXTREMITY <input type="checkbox"/> R <input type="checkbox"/> L
BODY PART

<input type="checkbox"/> Contrast/No Contrast at the Radiologist's discretion and may modify protocol.	<input type="checkbox"/> W/IV Contrast	<input type="checkbox"/> W/O IV Contrast	<input type="checkbox"/> W & W/O IV Contrast	<input type="checkbox"/> Oral Contrast
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SPECIAL INSTRUCTIONS:

Patient Name: _____

D.O.B. _____ / _____ / _____ Diagnosis: _____

Test Date: _____ Time of Exam: _____

Fax report to: _____

Is there a chance that the patient may be pregnant? (yes) _____ (no) _____

X _____
Physician Signature _____ Date _____ Time _____

ULTRASOUND	
ABDOMEN	
<input type="checkbox"/> LIMITED (SPECIFY SINGLE ORGAN)	<input type="checkbox"/> COMPLETE
RETROPERITONEAL COMPLETE	<input type="checkbox"/>
RETROPERITONEAL LIMITED	
<input type="checkbox"/> SPLEEN	<input type="checkbox"/> RENAL
<input type="checkbox"/> AORTA	<input type="checkbox"/> IVC
PELVIS (WITH TV IF NECESSARY)	
<input type="checkbox"/> COMPLETE	<input type="checkbox"/> FOLLOW-UP
PREGNANCY COMPLETE (WITH TV IF NECESSARY)	
<input type="checkbox"/> LESS THAN 14 WEEKS	<input type="checkbox"/> MORE THAN 14 WEEKS
PREGNANCY FOLLOW-UP (WITH TV IF NECESSARY)	<input type="checkbox"/>
SCROTUM & CONTENTS	<input type="checkbox"/>
SOFT TISSUE THYROID	<input type="checkbox"/>
EXTREMITY	

VASCULAR STUDIES	
CAROTID DOPPLER	<input type="checkbox"/>
BILATERAL LOWER EXTREMITY VENOUS DOPPLER	<input type="checkbox"/>
UNILATERAL LOWER EXTREMITY VENOUS DOPPLER	
<input type="checkbox"/> R	<input type="checkbox"/> L

MAMMOGRAPHY	
BHM BREAST HEALTH AT THE IMAGING CENTER SCHEDULING (765) 751-2727	
SCREENING	<input type="checkbox"/>
DIAGNOSTIC	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> BILATERAL
BREAST ULTRASOUND	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> BILATERAL
OTHER (SPECIFY)	

X-RAYS			
CHEST			
<input type="checkbox"/> TWO VIEW	<input type="checkbox"/> ONE VIEW	<input type="checkbox"/> LORDOTIC	<input type="checkbox"/> OBLIQUES
RIBS	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BILATERAL
RIBS W/CHEST	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BILATERAL
ABDOMEN			
<input type="checkbox"/> ONE VIEW KUB	<input type="checkbox"/> TWO VIEW COMPLETE	<input type="checkbox"/> THREE VIEW ACUTE	
SINUSES	<input type="checkbox"/> ROUTINE	<input type="checkbox"/> LIMITED	
SPINE			
CERVICAL	<input type="checkbox"/> ROUTINE	<input type="checkbox"/> OBLIQUES	<input type="checkbox"/> FLEX/EXT
THORACIC		<input type="checkbox"/> ROUTINE	
LUMBAR		<input type="checkbox"/> ROUTINE	
<input type="checkbox"/> OBLIQUES	<input type="checkbox"/> FLEX/EXT	<input type="checkbox"/> STANDING	
SCOLIOSIS			<input type="checkbox"/>
PELVIS			
HIP	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BILATERAL
KNEE	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BILATERAL
	<input type="checkbox"/> ROUTINE	<input type="checkbox"/> STANDING	<input type="checkbox"/> PATELLA
SHOULDER	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BILATERAL
HUMERUS	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BILATERAL
ELBOW	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BILATERAL
FOREARM	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BILATERAL
FEMUR	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BILATERAL
TIBIA/FIBULA	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BILATERAL
ANKLE	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BILATERAL
FOOT	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BILATERAL
HAND	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BILATERAL
WRIST	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BILATERAL
CARPAL SERIES	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BILATERAL
FINGER (SPECIFY DIGIT)			<input type="checkbox"/>
TOE (SPECIFY)			<input type="checkbox"/>
OTHER (SPECIFY)			

SPECIAL INSTRUCTIONS: