



SCHEDULING: 813-353-XRAY (9729)
SCHEDULING FAX: 813-348-6966

SOUTH TAMPA **ARMENIA**
 2222 W. Swann Ave., Tampa, FL 4516 N. Armenia Ave., Tampa, FL
 813-259-1900 F: 813-259-1999 813-348-6900 F: 813-348-6998

OLDSMAR
 3870 Tampa Road, Oldsmar, FL
 813-855-8282 F: 813-855-1973

Date _____
 Patient Name _____ DOB _____
 Appointment Date _____ Time _____
 Clinical Indications/Symptoms _____
 Ordering Physician (Please Print) _____
 Physician Signature _____

<input type="checkbox"/> Compare with: _____	<input type="checkbox"/> Fax Preliminary Report: _____
<input type="checkbox"/> CC Report to Dr. _____	<input type="checkbox"/> CD <input type="checkbox"/> Film: To go with Patient
<input type="checkbox"/> Hold Patient - Phone Report	<input type="checkbox"/> CD <input type="checkbox"/> Film: Deliver with Report
<input type="checkbox"/> Duplicate Report To: _____	<input type="checkbox"/> Stat Call Report to MD: _____

MRI

- | | | |
|--------------------------|--------------------------|--------------------|
| W/O | W & W/O | CONTRAST |
| <input type="checkbox"/> | <input type="checkbox"/> | Brain |
| <input type="checkbox"/> | <input type="checkbox"/> | Brain / Pituitary |
| <input type="checkbox"/> | <input type="checkbox"/> | Brain / IAC's |
| <input type="checkbox"/> | <input type="checkbox"/> | Orbits |
| <input type="checkbox"/> | <input type="checkbox"/> | TMJ's |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck |
| <input type="checkbox"/> | <input type="checkbox"/> | angio of Brain |
| <input type="checkbox"/> | <input type="checkbox"/> | angio of Carotid |
| <input type="checkbox"/> | <input type="checkbox"/> | angio of Renal |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast |
| <input type="checkbox"/> | <input type="checkbox"/> | C-spine |
| <input type="checkbox"/> | <input type="checkbox"/> | T-spine |
| <input type="checkbox"/> | <input type="checkbox"/> | L-spine |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdomen MRCP |
| <input type="checkbox"/> | <input type="checkbox"/> | Pelvis |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder __ R __ L |
| <input type="checkbox"/> | <input type="checkbox"/> | Elbow __ R __ L |
| <input type="checkbox"/> | <input type="checkbox"/> | Wrist __ R __ L |
| <input type="checkbox"/> | <input type="checkbox"/> | Hand __ R __ L |
| <input type="checkbox"/> | <input type="checkbox"/> | Hip __ R __ L |
| <input type="checkbox"/> | <input type="checkbox"/> | Knee __ R __ L |
| <input type="checkbox"/> | <input type="checkbox"/> | Ankle __ R __ L |
| <input type="checkbox"/> | <input type="checkbox"/> | Foot __ R __ L |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

FLUOROSCOPY

- BE
- BE w/air
- Barium Swallow - Esophagram
- GI Series
- Small Bowel Series
- Other: _____

DEXA SCREENING

- Oldsmar Location Only**
- Bone Density
 - Fracture(s) Body Composition Measurement

MAMMOGRAPHY

- Screening:** This exam is for patients who have no prior history of breast cancer, and who are not currently having any breast problems
- Diagnostic:** This exam is for patients who have active breast problems
- Unilateral:** _____

ULTRASOUND

- Abdomen (includes aorta, gallbladder, liver, kidneys, pancreas, spleen)
- Abdomen limited (includes gallbladder, liver, pancreas)
- Retroperitoneal
 - Aorta Kidneys
- Arterial
- Breast __ R __ L __ Bil
- OB < 14 wks > 14 wks
- Pelvis (Transabdominal)
- Pelvis (Transvaginal)
- Carotid
- Thyroid
- Testes
- Bladder
- Prostate
- Lower Extremity Arterial __ R __ L __ Bil
- Upper Extremity Arterial __ R __ L __ Bil
- Lower Extremity Venous __ R __ L __ Bil
- Upper Extremity Venous __ R __ L __ Bil
- Other: _____

LABORATORY

- BUN / Creatinine

CT SCAN

- | | | | |
|--------------------------|--------------------------|--------------------------|-----------------------------------|
| W | W/O | W & W/O | CONTRAST |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Brain |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sinus _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Facial Bones |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Orbits |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Neck |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chest |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chest High Resolution |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pulmonary Angiogram (for PE) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | CTA _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abdomen & Pelvis* |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abdomen* |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pelvis* |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Urogram |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abdomen & Pelvis (stone protocol) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cervical Spine w/ MPR |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thoracic Spine w/ MPR |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lumbar Spine w/ MPR |

Continued on the next column →

CT SCAN *Continuation*

- Extremity w/ MPR: _____ R __ L
- 3D Reconstruction
- Other: _____

**Most CTs of the abdomen or pelvis are performed with oral contrast unless otherwise specified.*

SPECIALS

- Arthrogram: __ R __ L
- CT MRI
- Hysterosalpingogram
- IVP
- Other: _____

PLAIN FILM

- Chest Pa/Lat
- Chest 1 View
- Sinus __ Full Series
- __ Waters View
- Facial Bones
- Spine Cervical
- Spine Thoracic
- Spine Lumbar
- Hand __ R __ L
- Wrist __ R __ L
- Elbow __ R __ L
- Forearm __ R __ L
- Humerus __ R __ L
- Shoulder __ R __ L
- Knee __ R __ L
- Ankle __ R __ L
- Foot __ R __ L
- Foreleg __ R __ L
- Femur __ R __ L
- Hip __ R __ L
- Pelvis
- Abdomen 3-Way
- Abdomen (KUB)
- Bone Age
- Other: _____