SEARHC
SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM

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IMAGING REQUEST FORM

Patient Name: (print clearly or place sticker here) DOB: MRN:	**Date:**
	Dept:
	Dept Ext:
Provider Name: (print clearly) **Provider Signature:** **Date/Time:**	Provider Phone:
	Provider Fax:
Reason for Exam: (Patient history/signs and symptoms for medical necessity)	***Additional Notes/Specific Views:**

Pregnant: YES NO

Iodine Allergy? YES NO

Is Patient >=60 years old, have kidney disease or is a diabetic?
eGFR_____ Creatinine _____

XR Upper Ext		
	Clavicle	R L
	Shoulder min 2v	R L
	AC Joints Bilateral	W W/O
	Humerus min 2v	R L
	Elbow 2v	R L
	Forarm 2v	R L
	Wrist Complete min 3v	R L
	Hand Complete min 3v	R L
	Thumb Complete	R L
	Finger Complete*	R L
	Other:	R L
XR Lower Ext		
	Hip Complete min 2v	R L
	Femur 2v	R L
	Knee 2v	R L
	Knee 3v	R L
	Knee min 4v*	R L
	Knee Bilateral Standing	AP PA
	Tibia/Fibula 2v	R L
	Ankle Complete	R L
	Foot Complete	R L
	Calcaneus min 2v	R L
	Toe Complete*	R L
	XR Spine and Pelvis	
	Cervical Spine 2 or 3v	
	Cervical Spine 4v	
	Thoracic Spine 2v	
	Thoracic Spine 3v	
	Lumbar Spine 2 or 3v	
	Lumbar Spine 4v	
	Pelvis 1v	
	Pelvis 2v	
	Sacrum and coccyx min 2v	
	Bone Density	
	DEXA	

XR Chest		
	Chest Frontal 1v	
	Chest Frontal & Lateral 2v	
	Ribs Uni w/PA Chest min 3v	R L
	Other:	R L
Fluoroscopy		
	Esophagus Barium Swallow	
	UGI with KUB	
	Colon Barium Enema	
	Other:	
Ultrasound		
	Abdominal Complete	
	Abdomen Limited*	
	Pelvic Non-OB	
	Pelvic Limited Non-OB	
	Transvaginal Non-OB	
	OB 1st Trimester Single Gestation	
	OB 1st Tri Add gestation	
	OB after 1st tri Single Gestation	
	OB after 1st tri Add gestation	
	OB Detailed Single Gestation	
	OB Detailed Add Gestation	
	OB Limited	
	OB Limited Follow up	
	OB Transvaginal	
	Cranial	
	Scrotum	
	Extremity, non-vascular*	
	Soft tissue, head/neck*	
	Chest	
	Breast	R L
	Axillary	R L
	L.E. Non-Vascular Complete*	R L
	L.E. Non-Vascular Limited*	R L
	ECHO	
Mammogram		
	Mammo Screening	R L
	Mammo Diagnostic	R L
	Other:	

CT Computer Tomography			
	Contrast with	Contrast w/o	
			Abdomen & Pelvis
			IVP Ab & Pel
			Stone Study Ab & Pel
			Thorax
			Head
			Sinuses/Facial Bones*
			Temporal Bones/Orbits*
			Soft Tissue Neck
			Abdomen
			Pelvis
			Cervical Spine
			Thoracic Spine
			Lumbar Spine
			Upper Extermity*
			Lower Extermity*
			CTA Head
			CTA Neck
			CTA Chest non-coronary
			Low Dose Chest
			Other:
			Other:
MRI Magnetic Resonance Imaging			
			Brain
			Orbits/face/neck*
			Cervical Spine
			Thoracic Spine
			Lumbar Spine
			Chest
			Abdomen
			Pelvis
			Upper Extermity*
			Lower Extermity*
			MRA Brain/Head
			MRA Neck
			Other:

Technologist Area:

Tech Name:

Start Time: End Time:

CT/MRI Contrast:

Contrast amount:

XR Repeats:

Checked when order(s) are entered, scanned and completed in RadNet: _____ Date:_____ Initials:_____

Revised 06.28.2024