Imaging Order Form

JOHN MUIR HEALTH | UCSF Health

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

☐ MRI

Contrast: ☐ Yes ☐ No

MR Neuroradiology & ENT
- ☐ Brain
- ☐ Nasopharynx (w/ neck)
- ☐ Internal auditory canal
- ☐ Pituitary
- ☐ TMJ
- ☐ Orbits
- ☐ Sinus

MR Spine
- ☐ Cervical spine
- ☐ Thoracic spine
- ☐ Lumbar spine
- ☐ Total spine
- ☐ Neurogram

MR Vascular
- ☐ Intracranial MRA
- ☐ Cervical carotids / neck MRA

MR Body
- ☐ Full body
- ☐ Abdomen
- ☐ Pancreas
- ☐ Liver
- ☐ Pelvis
- ☐ TMJ
- ☐ Prostate

Chest/Cardiac
- ☐ Chest
  - ☐ Thyroid
  - ☐ Parathyroid
- ☐ Cardiac MRI

MR Body MRA
- ☐ MRA abdomen
- ☐ MRA thoracic
- ☐ Renal MRA
- ☐ Lower extremity w/ runoff
- ☐ Other: _____

MR Musculoskeletal
- ☐ **Right** ☐ **Left**
- ☐ Shoulder
- ☐ Elbow
- ☐ Wrist
- ☐ Hand
- ☐ Finger
- ☐ Hip
- ☐ Knee
- ☐ Ankle
- ☐ Foot

☐ CT

Contrast: ☐ Yes ☐ No

CT Neuroradiology & ENT
- ☐ Brain
- ☐ Orbits
- ☐ Temporal bone
- ☐ Neck
- ☐ Maxillofacial
- ☐ Sinus
- ☐ CT angiogram
  - ☐ SAH
  - ☐ Stroke

CT Spine
- ☐ Cervical spine
- ☐ Thoracic spine
- ☐ Lumbar spine

CT Body
- ☐ Chest
- ☐ Abdomen
- ☐ Pelvis
- ☐ CTA abd/pel
- ☐ Renal donor
- ☐ Liver donor

CT Miscellaneous
- ☐ Bilateral lower extremity runoff

☐ X-Ray

X-Ray Thorax
- ☐ Chest 2 views
- ☐ Ribs
- ☐ Sternum
- ☐ Clavicle
- ☐ Sterno-clavicular joints
- ☐ AC joints
- ☐ Abdomen

X-Ray Spine
- ☐ Cervical spine
- ☐ Thoracic spine
- ☐ Thoracolumbar spine
- ☐ Lumbar spine
- ☐ Sacrum/coccyx
- ☐ Scoliosis series
- ☐ Pelvis

X-Ray Lower Extremity
- ☐ **Right** ☐ **Left** ☐ **Bilat**
- ☐ Hip
- ☐ Femur
- ☐ Knee
- ☐ Tibia/fibula
- ☐ Ankle
- ☐ Foot
- ☐ Heel
- ☐ Toe
- ☐ Hip-to-ankle

X-Ray Upper Extremity
- ☐ **Right** ☐ **Left**
- ☐ **Bilat**
- ☐ Shoulder
- ☐ Humerus
- ☐ Elbow
- ☐ Forearm
- ☐ Wrist
- ☐ Hand
- ☐ Finger

X-Ray Head
- ☐ Skull
- ☐ Facial bones
- ☐ Nasal bones
- ☐ Orbits
- ☐ Mandible

X-Ray Misc. Exams
- ☐ Bone survey
  - ☐ Myeloma
  - ☐ Metabolic
  - ☐ Pediatric
- ☐ Bone age
- ☐ Shunt series
- ☐ Other: _____

☐ Ultrasound

US Abdomen
- ☐ Abdomen complete
- ☐ Abdomen w/ doppler
  - ☐ Pre-liver transplant
  - ☐ Post-liver transplant
- ☐ Renal/bladder only
- ☐ Kidney transplant

US OB/GYN
- ☐ Pelvis (uterus & ovaries)
- ☐ Pelvis w/ transvaginal imaging
- ☐ First trimester OB
  - ☐ Singleton

US Superficial Structures
- ☐ Thyroid/parathyroid
- ☐ Scrotum

US Vascular
- ☐ Venous (DVT): upper extremity
- ☐ **Right** ☐ **Left** ☐ **Bilat**

US Miscellaneous
- ☐ Soft tissue-give location: _____
- ☐ Other: _____

☐ DEXA

- ☐ DEXA bone density scan
- ☐ Spine/hip
- ☐ Spine/hip w/ TBS
- ☐ Forearm *(only order if patient had spinal surgery or bilateral hip replacement)*
- ☐ Vertebral FX assessment (VFA)

☐ PET/CT

Please specify one:
- ☐ Initial treatment strategy ☐ Subsequent treatment strategy
- ☐ **PETCT FDG Vertex to mid-thigh (Non-diagnostic CT)** – If no additional CT is required.
- ☐ **PETCT FDG Vertex to mid-toes (Non-diagnostic CT)** – If no additional CT is required.
- ☐ **PETCT Vertex to mid-thigh** – If any of the following additional diagnostic CTs are needed:
  ☐ neck ☐ chest ☐ abd/pelvis ☐ lower ext ☐ upper ext | ☐ **w/ contrast** ☐ **w/o contrast**
- ☐ **PETCT Vertex to toes** – If any of the following additional diagnostic CTs are needed:
  ☐ neck ☐ chest ☐ abd/pelvis ☐ lower ext ☐ upper ext | ☐ **w/ contrast** ☐ **w/o contrast**
  (CT without IV contrast because of medical contraindication to IV contrast)

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

Made accessible 3/24

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