



To schedule call: 651-290-8707
 Please complete and fax to: 651-726-2622

Patient Name: _____ Date of Birth: _____

Parent / Guardian: _____ Phone Number: _____

Appt. Preference: Today Specify, within: _____ days _____ weeks _____ months

Reason for Exam / Medical Necessity / Symptoms & Duration: _____

Dx (All indications): _____

Ultrasound		Fluoroscopy	
Exam	Specify		
<input type="checkbox"/> Head		<input type="checkbox"/> Video Swallow with Speech	
<input type="checkbox"/> Neck		<input type="checkbox"/> Esophagram	
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Limited	<input type="checkbox"/> Upper GI	
<input type="checkbox"/> Pelvis		<input type="checkbox"/> Small Bowel Follow Through	
<input type="checkbox"/> Hip	<input type="checkbox"/> In harness <input type="checkbox"/> Out of harness	<input type="checkbox"/> Colon	
<input type="checkbox"/> Brachial Plexus		<input type="checkbox"/> Colon Therapeutic	
<input type="checkbox"/> Joint: _____		<input type="checkbox"/> Cystogram	
<input type="checkbox"/> Aorta		<input type="checkbox"/> VCUG	
<input type="checkbox"/> Carotid		<input type="checkbox"/> Neck / Airway	
<input type="checkbox"/> Renal/Kidneys		<input type="checkbox"/> Chest	
<input type="checkbox"/> Renal/Bladder		<input type="checkbox"/> Myelogram	<input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbosacral
<input type="checkbox"/> Thyroid		<input type="checkbox"/> Arthrogram	<input type="checkbox"/> Left <input type="checkbox"/> Right
<input type="checkbox"/> Testicular			
<input type="checkbox"/> Venous Arm	<input type="checkbox"/> Left <input type="checkbox"/> Right		
<input type="checkbox"/> Venous Leg	<input type="checkbox"/> Left <input type="checkbox"/> Right		
<input type="checkbox"/> Arterial Arm	<input type="checkbox"/> Left <input type="checkbox"/> Right		
<input type="checkbox"/> Arterial Renal	<input type="checkbox"/> Left <input type="checkbox"/> Right		
<input type="checkbox"/> Arterial Leg	<input type="checkbox"/> Left <input type="checkbox"/> Right		
Ultrasound Guidance		Fluoro Guidance	
<input type="checkbox"/> Vascular access		Exam	Specify (progress of tube)
<input type="checkbox"/> Needle placement		<input type="checkbox"/> NG Tube Placement	
<input type="checkbox"/> Catheter placement		<input type="checkbox"/> NJ Tube Placement	
<input type="checkbox"/> Other:		<input type="checkbox"/> GJ Tube Check	Tube Size: _____

Scheduled For:

Date / Time: _____

Arrival Time: _____

Preparation: _____

Instructions:

	YES	NO
Allergies: _____	<input type="checkbox"/>	<input type="checkbox"/>
Ketogenic Diet	<input type="checkbox"/>	<input type="checkbox"/>
MRSA	<input type="checkbox"/>	<input type="checkbox"/>
Ventilator dependent	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Child Life Services	<input type="checkbox"/>	<input type="checkbox"/>
Interpreter needed:	<input type="checkbox"/>	<input type="checkbox"/>
Language: _____		
Previous Images (Non-Gillette):	<input type="checkbox"/>	<input type="checkbox"/>
Location: _____ Date: _____		

Fax Reports to Gillette Imaging: Fax: 651-229-3921

**Mail CD or film copies to: Gillette Childrens Imaging Dept.
 200 University Ave E
 St. Paul, MN 55101**

Other Orders/Instructions:

Provider Name: _____ Signature: _____ Date: _____

Print/ Stamp here

Phone Number: _____ Address: _____