



To schedule call: 651-229-3995
 Please complete and fax to: 651-265-7480

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): _____

CT	
Exam	Specify
<input type="checkbox"/> Head	
<input type="checkbox"/> Head- CT Angio	
<input type="checkbox"/> Orbits	
<input type="checkbox"/> Facial Bones, TMJ	
<input type="checkbox"/> Sinuses	
<input type="checkbox"/> Temporal Bones, IAC -Mastoid	
<input type="checkbox"/> Soft Tissue Neck	
<input type="checkbox"/> Cranio Cervical Jct	
<input type="checkbox"/> Cervical	
<input type="checkbox"/> Thoracic	
<input type="checkbox"/> Lumbar	
<input type="checkbox"/> Chest	
<input type="checkbox"/> Abdomen & Pelvis	<input type="checkbox"/> Kidney stone
<input type="checkbox"/> Abdomen Only	
<input type="checkbox"/> Pelvis Only	
<input type="checkbox"/> Shoulder	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat
<input type="checkbox"/> Humerus	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat
<input type="checkbox"/> Elbow	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat
<input type="checkbox"/> Forearm	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat
<input type="checkbox"/> Wrist	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat
<input type="checkbox"/> Hand	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat
<input type="checkbox"/> Hip	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat
<input type="checkbox"/> Femur	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat
<input type="checkbox"/> Knee	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat
<input type="checkbox"/> Tib Fib	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat
<input type="checkbox"/> Ankle	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat
<input type="checkbox"/> Foot	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat
<input type="checkbox"/> 3D Reconstruction	
<input type="checkbox"/> CT Angio (indicate body part):	

SCHEDULED FOR:
 Date / Time: _____ Arrival Time: _____
 Preparation: _____
 Pre-Notification #: _____

IV CONTRAST:

	YES	NO
IV Contrast	<input type="checkbox"/>	<input type="checkbox"/>
Previous contrast reaction (If yes, order prep)	<input type="checkbox"/>	<input type="checkbox"/>
Asthma (if yes, patient to bring inhaler)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease or Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>
Adrenal Tumor / Pheochromocytoma	<input type="checkbox"/>	<input type="checkbox"/>

INSTRUCTIONS:

Allergies: _____

MRSA

Ventilator dependent

Pregnant

Child Life Services

Interpreter needed:

Language: _____

Previous Images (Non-Gillette):

Location: _____ Date: _____

Fax outside 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

SEDATION: Requires H&P within 7 days
 Fax H&P to 651-726-2643

Other Orders / Instructions:

Provider Name: _____ Signature: _____ Date: _____

Print/ Stamp here

Phone Number: _____ Address: _____