CLAY COUNTY HOSPITAL
Your #1 Choice in Healthcare
911 Stacy Burk Dr. Flora, IL 62839 Phone: 618-662-1636 Fax: 618-662-1489

Diagnostic Imaging Services Order Form

INSURANCE PRECERT/RQI # _____

Facility Name:	**Ordering Physician**:
Patient Name:	**DOB:**
Ordering Date: ___/___/___	**Date & Time of Test**: **DATE:** ___/___/___ **TIME:** _____
Diagnosis:	
Diagnosis Code:	

Diagnostic Imaging X-Rays

Chest X-Ray	☐ 1 view ☐ 2 view
KUB	
Ribs	☐ RT ☐ LT ☐ Bilateral
C-Spine	
T-Spine	
L-Spine	
Pelvis	
Other------	
Wt. Bearing	
Lower Leg	
Ankle	
Foot	

☐ **RT** ☐ **LT** ☐ **Bilateral**	
Shoulder	
Humerus	
Elbow	
Forearm	
Wrist	
Hand	
Finger	
Hip	
Femur	
Knee	
Patella	
Toe	

CT Scan

Without IV Contrast	
With IV Contrast*	
Contrast Allergies	☐ Yes ☐ No
Head/Brain	
Sinuses/Facial Bones	
Soft Tissue Neck	
Chest	
Abdomen	
Pelvis	
Renal Stone Protocol	
C-Spine	
L-Spine	

CTA GFR

Brain/Circle of Willis	
Carotid/Neck	
Renal Artery	
Iliac Femoral Runoff	

Ultrasound

Carotid	
Echocardiogram	
Venous Doppler	☐ UPR ☐ LWR ☐ LT ☐ RT
Arterial Doppler	☐ ABI's
Abdomen	☐ Complete ☐ Limited
Gallbladder	
Aorta	
Thyroid	
Pelvic	
Breast	☐ Right ☐ Left
Testicular	
Soft Tissue Mass	
Renal	

Special Requests or Comments:

Mammogram

☐ RT ☐ LT ☐ Bilateral

DEXA

Bone Density	

Nuclear Medicine

Bone Scan	
Whole Body	
3 Phase	
Limited area	
Stress/Rest	
HIDA	
VQ/Lung Scan	
Thyroid Scan	
Thyroid Uptake**	

MRA GFR

Iliac Femoral Runoff	
Carotid/Neck	
Renal Artery	

MRI

Without IV Contrast	
With IV Contrast*	
Head/Brain	
Abdomen	
Pelvis	
Extremity	
Spine	

*GFR within 30 days (If not, GFR will be performed at CCH)

**No thyroid meds six weeks prior to test.

Physician Signature: _____ **Date/Time:** _____

Printed Physician Name: _____