



Miami Valley Hospital
Atrium Medical Center
Upper Valley Medical Center

OUTPATIENT SERVICES
Medical Imaging/Diagnostic Testing

To schedule an appointment call: (937) 499-7364, (855) 887-7364 (toll free) or fax order to: (937) 641-2336

*Indicates items required for a complete order

*Patient Name (printed):		*Date of Birth:	
Patient Phone #:	Patient Alternate #:	Insurance:	
*ICD Diagnosis Code(s) Symptoms or Complaint:			
*Physician Name (printed):		*Date:	*Time:
*Physician Signature:		Special Instructions:	

GENERAL XRAY			
Abdomen/Series			
Abdomen/KUB			
Chest			
Sinus			
Pelvis			
Skull			
Soft Tissue neck			
Spine <input type="checkbox"/> Cervical <input type="checkbox"/> Lumbar <input type="checkbox"/> Thoracic <input type="checkbox"/> w/Obliques <input type="checkbox"/> w/Flexion & Extension			
Sacrum/Coccyx			
Ankle	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BIL
Elbow	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BIL
Femur	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BIL
Foot	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BIL
Forearm	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BIL
Hand	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BIL
Hip	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BIL
Humerus	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BIL
Knee	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BIL
Lower Leg	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BIL
Ribs	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BIL
Shoulder	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BIL
Wrist	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BIL
Other - Specify: _____			

FLUOROSCOPIC PROCEDURES	
Arthrogram: specify _____	
<input type="checkbox"/> w/CT <input type="checkbox"/> w/MRI	
Cystogram <input type="checkbox"/> voiding	
Hysterosalpingogram	
Esophagram	
Upper GI	
Small Bowel	
Barium Enema/Colon <input type="checkbox"/> w/air	
Intravenous Pyelogram (IVP)	
Modified barium swallow/video fluoroscopy	

MAMMOGRAPHY			
Screening Mammogram with 3D			
Diagnostic Mammogram	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BIL
Breast Imaging Workup/Diagnostic/Mammo			
<input type="checkbox"/> Breast US if indicated			
<input type="checkbox"/> Image Guided Asp./Biopsy if indicated			
<input type="checkbox"/> Breast MRI if indicated			
<input type="checkbox"/> Ductogram if indicated			
Stereotactic Biopsy	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BIL
Needle Localization	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BIL
US Guided Breast Biopsy	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BIL
Dexa Bone Density			
Trabecular Bone Score			
Other - Specify: _____			

ULTRASOUND			
Abdomen Complete			
Abdomen Limited (ie: RUQ)			
Biophysical Profile			
Bladder			
Breast Limited	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BIL
Breast Complete	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BIL
Kidney			
OB			
<input type="checkbox"/> Transvaginal if indicated			
Pelvis			
<input type="checkbox"/> Transvaginal if indicated			
Testicular			
Thyroid			
Liver Elastography			
Other - Specify: _____			

VASCULAR ULTRASOUND			
ABI only			
Arterial Duplex			
Arterial Doppler Study/PVR			
<input type="checkbox"/> Lower <input type="checkbox"/> Upper			
Carotid			
Vein Mapping <input type="checkbox"/> Lower <input type="checkbox"/> Upper			
<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> BIL			
Venous Doppler Studies <input type="checkbox"/> Lower <input type="checkbox"/> Upper			
<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> BIL			
Other - Specify: _____			

CARDIOLOGY			
12-Lead ECG			
24-Hour Holter Monitor			
48-Hour Holter Monitor			
2-D Echo			
ECHO <input type="checkbox"/> Treadmill <input type="checkbox"/> Dobutamine			
Stress EKG (Treadmill only)			
Cardiac Nuclear Stress: <input type="checkbox"/> Medicated <input type="checkbox"/> Treadmill			
MUGA Scan			
Event Monitor			
Other - Specify: _____			

RESPIRATORY			
ABG <input type="checkbox"/> w/O2 (specify _____ lpm) <input type="checkbox"/> w/o O2			
Complete PFT (includes volumes and diffusion)			
Complete PFT with Bronchodilator (includes volumes, diffusion and bronchodilator)			
Spirometry (includes SVC and FVC)			
Spirometry with bronchodilator (includes SVC, FVC and bronchodilator)			
Pulmonary Exercise Stress test			
MVV (maximum voluntary ventilation)			
Methacholine Challenge			
PI Max/PE Max (also called MIP/MEP)			
Other - Specify: _____			

EMG			
EMG/NCS <input type="checkbox"/> Lower <input type="checkbox"/> Upper <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> BIL			

NEURODIAGNOSTICS			
AEEG - Ambulatory EEG			
Evoked Potential Auditory			
Evoked Potential Visual			
Evoked Potential Somatosensory Upper Ext			
Evoked Potential Somatosensory Lower Ext			
Routine EEG			

NUCLEAR MEDICINE/PET			
Bone Scan <input type="checkbox"/> Whole Body <input type="checkbox"/> 3-phase <input type="checkbox"/> Limited			
Cardiac Stress: <input type="checkbox"/> Pharmacological <input type="checkbox"/> Treadmill			
MUGA Scan			
Gall Bladder <input type="checkbox"/> w/CCK <input type="checkbox"/> w/o CCK			
Gastric Emptying <input type="checkbox"/> Liquid <input type="checkbox"/> Solid			
Gallium			
Lung Scan ventilation/perfusion			
Parathyroid			
Renal - Specify: <input type="checkbox"/> Flow/function <input type="checkbox"/> x/Lasix <input type="checkbox"/> w/Captopril			
Thyroid Uptake/Scan <input type="checkbox"/> Single <input type="checkbox"/> Multi			
PET/CT-Specify: _____			
Other - Specify: _____			

CT			
All exams listed below are contrast per radiologist protocol. For specific contrast request, indicate under Other.			
Abdomen			
Abdomen/Pelvis			
Chest			
Extremity-Specify:			
Head			
Neck			
Pelvis			
Spine: <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar			
CT Angiography-Specify:			
CT Lung Screening			
Calcium Scoring			
*Other - Specify: _____			

MRI			
All exams listed below are contrast per radiologist protocol. For specific contrast request, indicate under Other.			
Abdomen			
Ankle	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BIL
Brachial Plexus			
Breast			
Fast Breast Screening			
Chest			
Elbow	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BIL
Extremity (non joint) Specify:			
Head/Brain			
Hip	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BIL
Knee	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BIL
Pelvis			
Shoulder	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BIL
Soft Tissue Neck			
Spine: <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar			
Wrist	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> BIL
MR Angiography Specify:			
*Other - Specify: _____			

Scheduled Date _____ Time _____ Comments _____