

Other____

☐ Baydoun Shoulder Protocol

Form # RAD-2944-LV Orig 2/93 Rev 1/13

Imaging Services

Computed Tomography (CT) Order One Nolte Drive - Kittanning, PA 16201

Imaging Service Scheduling 724-543-8131 Fax 724-543-8855

Place Label HERE

Acct #

Contingency Order Info for MT Downtime

Prep CT#2 - Clear liquids only 6 hours prior to exam,

obtain bottle of Redi-cat from x-ray department and

Prep CT#3 - Nothing to eat or drink after midnight.

drink 2 hours prior to exam.

MR#

Room #

Physician Signature		
Physician PRINTED Name (required)		
Patient Name		Please follow the preparation listed below
DOB SSN		and bring this form and any referrals needed to the Outpatient Registration desk 1/2hour before your appointment. If you have been
Address		pre-registered by phone, please arrive 15 minutes before.
Phone Number	Gender M / F	
Primary Insurance:	DIAGNOSIS (Include	e ICD9)
Policy Number:		(Required)
	Auth N	umber: Required based on Insurance Policy
COMPUTED TOMOGRAPHY (CT) Brain (prep CT#1) Brain Unehanced Sinus Orbit/Facial Bones Soft Tissue Neck (prep CT#1) Chest (prep CT#1) Chest Unenhanced Chest Angio (PE) High Resolution Chest Abdomen (prep CT#2)		Appointment Date:
		Location: ACMH Hospital Imaging Center
Abdomen/Pelvis complete survey (prep CT#2) Abdomen/Pelvis for Kidney Stones Pelvis (prep CT#2)	ructions For Scheduling changes, please call: 724-543-8131	
Cervical Spine with Reconstructions Thoracic/Dorsal Spine W/ Reconstructions		
Lumbar Spine with Reconstructions CTA(prep CT#1) Guidance for Abscess Drainage (prep CT#3) Guidance for Cyst Aspiration (prep CT#3) Guidance for Needle Biopsy (prep CT#3)	To Pre-Regis	ter for your appointment, please call 724-543-8832
	A <u>signed</u> phy	ysician order is required at the time of your appointmer
Guidance for Radiation Field Placement Extremity with Reconstructions Rt Lt (circle one)	CT Prep	<u>List</u>
(511010 0110)	Prer	o CT#1 - Clear liquids only 6 hours prior to exam