AMMC Medical Imaging Form

Please contact medical imaging for questions at **307-352-8934**

Please fax order and patient demographics to **307-352-8959**

Date	**Patient Phone# (Required)**
Patient Name	**DOB**
ICD10	**Diagnosis**
Physician Name	**Physician Signature**
STAT ◯ Y ◯ N	**Call Results To #**

Ultrasound

- O Abdomen Complete
- O Abdomen Limited
  - O RUQ (Liver, GB)
  - O Other_____
- O Gallbladder w/ Kinevac
- O Renal/Bladder
- O Pelvic (with Transvaginal if indicated)
- O Transvaginal Only
- O Soft Tissue Neck
- O Thyroid
- O Breast / Axilla
  ◯ R ◯ L ◯ Bilateral
- O Soft Tissue Mass
  Specify Area_____
- O Testicular
- O Other_____

Ultrasound Vascular

(Bilateral – Unless otherwise stated)

- O Aorta
- O Carotid
- O Arterial Doppler
  ◯ R ◯ L
- O Venous Doppler (R/O DVT)
  Upper Extremity ◯ R ◯ L
  Lower Extremity ◯ R ◯ L
- O Venous Insufficiency
  (Lower Extremity)
  ◯ R ◯ L

Ultrasound Special Procedures

- O Thyroid FNA/Biopsy
- O Thoracentesis
- O Paracentesis
- O US Guided Injection
  Specify Area:
  _____
- O US Guided Biopsy
  Specify Area:
  _____
- O US Guided Needle Aspiration
  Specify Area:
  _____
- O US Guided Breast Biopsy/Asp/Loc w/ Clip Placement
  ◯ R ◯ L
- O US Guided Venous Access

3D Mammography

Implants ◯ Y ◯ N

- O Screening
  ◯ R ◯ L ◯ Bilateral
- O Diagnostic (w/ US if Indicated)
  ◯ R ◯ L ◯ Bilateral

Special Procedure Labs

◯ Urine Pregnancy

Fluoroscopy

- O PICC Line Placement
- O Lumbar Puncture
- O Pain Injection
  Joint: _____ ◯ R ◯ L
  Spine: _____ ◯ R ◯ L
- O Esophagram
- O Upper GI
- O Small Bowel Follow Through
- O UGI w/ SBFT
- O Other_____

Digital X-ray

Please Specify Body Part

(A complete exam will be performed unless otherwise specified)

_____

This is order form 2 of 2. Please refer to order form 1 of 2 for MRI and CT procedures