



The Kirklin Clinic

Department of Radiology
Radiology Research Order Form

Patient Name: _____
Date of Birth: _____
Medical Record Number: _____
Date of Service: _____
Physician: _____

NOTE: THIS FORM IS TO BE COMPLETED ONLY IF ITEMS ARE TO BE BILLED TO A RESEARCH STUDY

IRB #: _____ Subject ID: _____
Name of Study: _____ Name of Principal Investigator: _____
Name of Study Coordinator: _____ Telephone #: _____ Pager # _____
Name of Sponsor: _____ Special Instructions: _____

SPECIAL SERVICE REQUEST:

- Orderable Name: _____
 Tumor Metrics (e.g., RECIST) Questionnaire/Paperwork Related to Patient Scan
 Phantom Scan Other: _____
 Without Contrast With Contrast Without followed with Contrast Signed Order in Clinic Chart

Please note: Any exam requiring contrast administration, CT or MRI, must have a current (< 90 days) creatinine.
If renal function was abnormal, a more recent value would be required.

Completed By: _____
Physician Signature: _____

*Indicates Prep Required

GI/GU Imaging	Ultrasound Imaging	MRI
Abdomen/KUB/Abdominal Series	Abdomen	Head-MRI
* Barium Swallow	* Abdomen with Dopplers	Brain
* Enema Barium	* Aorta	Facial Bones/Sinuses
* Enema Water Soluble	Carotid	Orbits
* Esophogram - Modified	Diagnostic Paracentesis	MRA (intracranial)
* Esophogram - Water Soluble	Diagnostic Thoracentesis	MRV
* IVP	Fine Needle Aspiration:	Cisternogram
Retrograde Urethrogram	Groin	CSF Flow Study
* Small Bowel Series	Lower Extremity Veins	Perfusion
T-Tube Cholangiogram	Mark for Liver Biopsy	Spectroscopy
* Upper GI	Parathyroid	TMJ
* Upper GI Water Soluble	Pelvis	Other
VCUG	Penile	Neck-MRI
Other	Post-Op Arm	Cervical Spine
Bone and General Imaging	Renal	Soft Tissue Neck
AC Joints	Renal Transplant	Brachial Plexus R L
Ankle R L	Renal with Dopplers	MRA (Extracranial-Arch to Circle of Willis)
Cervical Spine	Scrotal	MRA Subclavian Only R L
Chest	Soft Tissue	Other
Clavicle R L	Therapeutic Paracentesis	Torso-MRI
Elbow R L	Therapeutic Thoracentesis	Breast
Femur R L	Thyroid	Chest Wall (Musculoskeletal)
Foot/Toe R L	Upper Extremity Veins	Ribs
Forearm R L	Vein Mapping	Thoracic Spine
Hand/Finger R L	Other	Abdomen
Hip R L	Cat Scan	MRA (specify)
Humerus R L	Neuro-CT	MRV (specify)
Knee R L	Cervical Spine	Body Pelvis (i.e. fibroids)
Lower leg R L	* CTA (angio) Head	Bony Pelvis
Lumbar Spine R L	* CTA Neck	Lumbar Spine
Mandible R L	* Head	Lumbar Plexus
Pelvis R L	Lumbar Spine	Sacrum
Ribs	* Neck	Gluteus
Scapula R L	* Orbits	Spectroscopy
Scoliosis Series R L	* Maxillo/Facial (non-sinusitis)	Other
Shoulder	Sinus/ (sinusitis)	Extremity-MRI
SI Joints R L	* Temporal Bones/IAC	Ankle R L
Sinuses	Thoracic Spine	Ankle with Arthrogram R L
Skull	Chest-CT	Elbow R L
Sternum	* Chest	Elbow with Arthrogram R L
Thoracic Spine	* Chest for PE	Femur/ Thigh R L
Water's View Sinus	* CTA Chest	Foot R L
Wrist R L	High Resolution Chest	Forearm R L
Other	Body-CT	Hand R L
Mammography	* 3 Phase Liver	Hip R L
Breast Ultrasound	* 3 Phase Liver with Pelvis	Hip with Arthrogram R L
Core Biopsy	* 3 Phase Pancreas	Humerus R L
Diagnostic Mammogram	* 3 Phase Pancreas with Pelvis	Knee R L
Pre-Operative Localization	* Abdomen and Pelvis	Knee with Arthrogram R L
Screening Mammogram	* Abdomen Only	MRA (specify)
Ultrasound Guided Aspiration	* Adrenal	MRV (specify)
Ultrasound Guided FNA	* CTA Abdomen and Pelvis	Shoulder R L
Other	* CTA Runoff	Shoulder with Arthrogram R L
Clinic: _____	* Enterography	Tibia/ Fibula/Calf R L
Contact Person: _____	* Pelvis Only	Wrist R L
Contact Phone: _____	Renal for Kidney Stones	Wrist with Arthrogram R L
Appt Date/Time: _____	* Renal Donor	Other
Request must be faxed to 205 731-5688	* Renal for all other	3D Reconstructed Images of MRI
If the patient is scheduled for an MRI, please ask the patient to call 205 502-9933 for the pre-screening MRI safety Interview.	Musculoskeletal-CT	If this patient should require anxiety management for MRI, please have the physician circle the medication of choice and sign the request. Patient will need to arrive one hour prior to appointment and bring responsible driver. Ativan 1 mg-2mg PO x 1 dose Valium 5 mg-10 mg PO x 1 dose Xanax 0.25 mg- 0.5 mg PO x 1 dose
	Bony Pelvis	
	Lower Extremity (specify) R L	
	Sacrum	
	SI Joints	
	Upper Extremity (specify) R L	
	Other	
	3D Reconstructed Images of CT	
	Pet Scan	
	Whole Body PET	

Physician Signature _____ Date _____