CT ORDER FORM

2900 12th Avenue North, Suite 3E
Yellowstone Medical Center
Billings, MT 59101
Phone: 406-237-5525
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Physician Referral Order Form

Patient Information

Today's Date: ____/____/____ Appointment Date: ____/____/____ Appointment Time: ________ Arrival Time: ________

Patient Name: ______________________________ Date of Birth: _____/_____/_____

Gender: ☐ Male ☐ Female Phone: (________)________________________

Follow up appointment: ☐ Not Scheduled ☐ Date: ____/____/____ Time: __________

Previous imaging studies? ☐ Yes ☐ No Where? ☐ Big Sky ☐ Other: ________________

Referring Physician

Name: ____________________ Phone: ____________

Clinic: ____________________ Fax: ____________

Signature:

Reports and Delivery

☐ ASAP

☐ Phone Report # ____________________

☐ Fax Report # ____________________

☐ Report & Images on CD

☐ Send CD with Patient

☐ Send copy to: ____________________

Computed Tomography (CT)

IV Contrast

	With only	*Without only*	*With/Without*	
Head				
☐ Head	☐	☐	n/a	
☐ Orbits	☐	☐	n/a	
☐ Temporal bones	☐	☐	n/a	
☐ Sinus	☐	☐	n/a	
☐ Facial Bones	☐	☐	n/a	
Spine				
☐ Cervical Spine	☐	☐	n/a	
☐ Thoracic Spine	☐	☐	n/a	
☐ Lumbar Spine	☐	☐	n/a	
Body				**Oral Contrast*
☐ Soft Tissue/ Neck	☐	n/a	n/a	
☐ Chest	☐	☐	n/a	
☐ Abdomen	☐	☐	☐	☐
☐ Pelvis	☐	☐	☐	☐

Orthopedic

☐ Upper extremity: ____________________ ☐ Right ☐ Left

☐ Lower extremity: ____________________ ☐ Right ☐ Left

Contrast Screening:

Has the patient had a previous reaction to iodinated contrast? ☐ Yes ☐ No

Is the patient diabetic or does the patient have renal disease? ☐ Yes ☐ No

Is the patient over 70? ☐ Yes ☐ No

(If yes to any, current renal function labs needed.)

Angiography

☐ Head

☐ Neck

☐ Pulmonary

☐ Chest

☐ Aorta

☐ Abdomen

All CTA exams require IV contrast

Reason for CT - Diagnosis Code(s):

____

____

Special Instructions

____

Other Exam

☐ ____________________________

**Oral contrast is used for abdomen/pelvis only. See administration instructions.*

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