

UNIVERSITY OF MICHIGAN HOSPITALS & HEALTH CENTERS

Radiology Requisition

<input type="checkbox"/> Routine	<input type="checkbox"/> Stat	Results Reporting
<input type="checkbox"/> Urgent		Location Code
Order date:		
ICD-9 codes:		

NAME	DOB:
UMHS REG NO	Sex:
DOS:	
ACC:	
Bill to Research Account:	700

Clinical Indications (please fill out a separate form for each modality)

Interpret Outside Films/Images (list exam type & attach OSH report if available)

Ordering Clinician to receive report	UMHS Dr. #
See label above <input type="checkbox"/>	
Attending Physician if different:	UMHS Dr. #

Scheduling Exams - Call Center (734) 936-4500

<http://www.med.umich.edu/rad/preps/radoc.htm>

Additional Imaging, including 3D will be performed as indicated by Radiologist.

Notify me before additional imaging is performed.

Appt. Date: _____ Time: _____ Location: _____

Patient Safety/Communications

Contrast Allergy Any Severe Allergy Asthma

<http://www.med.umich.edu/rad/preps/steroid-benadryl-prep.pdf>

Pregnant Falls Precautions

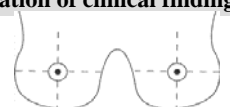
Interpreter needed (specify): _____

Breast Imaging

Screening Mammography Diagnostic Mammography

Procedures Please Indicate location of clinical finding

Core Biopsy Fine Needle Aspiration Wire Localization

Right  Left

Breast Ultrasound MR Breast Other: _____

General Imaging (walk-in, no appointment necessary)

Chest PA/LAT PA

Rib detail (specify): _____

Abdomen: _____

Pelvis _____

Hip **R L**

Skull (specify) _____

Cervical Spine _____

T-Spine _____

Lumbar Spine Sacrum

Scoliosis Skeletal Survey

Computed Tomography (CT)

Pre-exam Questionnaire: (submit with requisition)

<http://www.med.umich.edu/rad/preps/QuestionnaireCT.pdf>

Cardiac (specify): _____

CT Calcium Scoring - patient is symptomatic or _____ asymptomatic

<input type="checkbox"/> Chest	<input type="checkbox"/> Neck(soft tissue)	<input type="checkbox"/> Head (Brain)
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> Facial Bone
<input type="checkbox"/> Renal Stone	<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/> Orbit
<input type="checkbox"/> PE	<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/> Sinus
<input type="checkbox"/> Pelvis	CTA (specify): _____	
<input type="checkbox"/> Bone Pelvis	CT Urogram	
<input type="checkbox"/> Extremity R L (specify)	CT Enterography	
Other: _____		

Upper Extremity **Lower Extremity**

<input type="checkbox"/> Shoulder	R L	<input type="checkbox"/> Femur	R L
<input type="checkbox"/> Humerus	R L	<input type="checkbox"/> Knee	R L
<input type="checkbox"/> Elbow	R L	<input type="checkbox"/> Tibia/Fibula	R L
<input type="checkbox"/> Forearm	R L	<input type="checkbox"/> Ankle	R L
<input type="checkbox"/> Wrist	R L	<input type="checkbox"/> Foot	R L
<input type="checkbox"/> Hand	R L	Other: _____	

Magnetic Resonance Imaging (MRI)

Pre-exam Questionnaire: (submit with requisition)

<http://www.med.umich.edu/rad/preps/QuestionnaireMRI.pdf>

<input type="checkbox"/> Cardiac	<input type="checkbox"/> Cervical Spine
<input type="checkbox"/> Chest	<input type="checkbox"/> Thoracic Spine
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Lumbar Spine
<input type="checkbox"/> Pelvis	<input type="checkbox"/> Pelvis (musculoskeletal)
<input type="checkbox"/> Brain	<input type="checkbox"/> Neck <input type="checkbox"/> Breast
<input type="checkbox"/> Extremity R L (specify)	<input type="checkbox"/> Post Arthrogram
MRA (specify): _____	
Other: _____	

Nuclear Medicine (NM)

General	Cardiac
<input type="checkbox"/> Bone Scan <input type="checkbox"/> w SPECT	Myocardial Perfusion:
<input type="checkbox"/> DEXA-Bone Densitometry Scan	<input type="checkbox"/> With or <input type="checkbox"/> Without
<input type="checkbox"/> Dynamic Renal (For obstruction)	Calcium Scoring
<input type="checkbox"/> Gastric Emptying	<input type="checkbox"/> Stress SPECT <input type="checkbox"/> Rest SPECT
<input type="checkbox"/> Hepatobiliary (HIDA)	<input type="checkbox"/> Stress PET
<input type="checkbox"/> Leukocyte/Infection	<input type="checkbox"/> Pharmacologic:
<input type="checkbox"/> Lung V/Q	<input type="checkbox"/> Treadmill:
<input type="checkbox"/> Lymphoscintigraphy (Sentinel Node)	Myocardial Viability:
<input type="checkbox"/> MIBG	<input type="checkbox"/> Rest PET Perfusion
<input type="checkbox"/> Octreoscan	<input type="checkbox"/> Rest SPECT Perfusion
<input type="checkbox"/> Thyroid Scan <input type="checkbox"/> I131 Uptake	Radionuclide Ventriculography:
<input type="checkbox"/> Other: _____	<input type="checkbox"/> MUGA
PET	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Tumor	
<input type="checkbox"/> Brain <input type="checkbox"/> Other: _____	

Ultrasound (US)

<input type="checkbox"/> Abdomen	<input type="checkbox"/> RUQ <input type="checkbox"/> Kidney
<input type="checkbox"/> Obstretical	<input type="checkbox"/> Pelvis <input type="checkbox"/> Testicular
<input type="checkbox"/> Aorta	<input type="checkbox"/> Extremity R L (specify): _____
<input type="checkbox"/> Carotids	<input type="checkbox"/> Thyroid
Other (specify): _____	

Angio/Interventional procedure (IR) **CT/US Interventional procedure call (734) 615-3486**

Department of Radiology

The following patients will require premedication before receiving intravascular for CT, IR, IVP or MR exams:

1. All prior allergic-like reactions to iodinated contrast material if requesting CT, IR, IVP or Gadolinium if requesting MR.

<p>This includes:</p> <ul style="list-style-type: none">• ALL allergic like reactions, whether considered mild, moderate or severe, including most skin reactions (hives, rash, erythema, itching, nasal congestion)• facial or body edema• bronchospasm• laryngeal edema• difficulty breathing• hypotension• any allergic-like reaction requiring hospitalization or an ER visit• cardiopulmonary arrest	<p>This does NOT include the following non allergic reactions:</p> <ul style="list-style-type: none">• vasovagal reaction• nausea• vomiting• contrast-induced renal dysfunction
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2. Any severe allergic reaction to any substance .

(UNLESS THE PATIENT HAS PREVIOUSLY RECEIVED CONTRAST MATERIAL WITHOUT A PROBLEM)

<p>This includes:</p> <ul style="list-style-type: none">• ALL severe allergic-like reactions• marked facial or body edema• severe bronchospasm• severe laryngeal edema• substantial difficulty breathing• profound hypotension• other allergic-like reaction requiring hospitalization or an ER visit• cardiopulmonary arrest	<p>This does NOT include:</p> <ul style="list-style-type: none">• milder symptoms not listed at left, such as rash, hives or mild respiratory symptoms
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For iodinated contrast only (CT, IR, IVP):

3. Currently taking daily either two medications or a single combination agent for asthma.

In circumstances where premedication is required, consideration should always be given to performing the examination without IV contrast, if the diagnostic information required can be obtained in that manner, or alternate imaging modalities that do not require iodinated intravenous contrast, such as US or MR.

Health care providers may choose to provide premedication in other circumstances, but that is at the discretion of both the health care provider and the patient, and is not required for the administration of iodinated contrast within the Department of Radiology

HOW TO PREMEDICATE for Adult Patient

Standard oral premedication regimen:

- *Prednisone – 50 mg PO, 13, 7, and 1 hour prior to the procedure**
- *Diphenhydramine – 50 mg PO 1 hour prior to the procedure*

*Note: doses may be distributed unevenly to allow a patient to get a reasonable night's sleep the evening prior to the CT; however, the first dose should be taken more than 12 hours before the time the exam is scheduled to be performed

Alternate IV protocol if a patient cannot take oral medications:

- *Hydrocortisone – 200 mg IV, 13, 7, and 1 hour prior to the procedure*
- *Diphenhydramine – 50 mg IM or IV, 1 hour prior to the procedure*

Urgent IV premedication protocol, when iodinated contrast is needed on an urgent/emergent basis only:

- *Hydrocortisone – 200 mg IV, 5 hours and 1 hour prior to the procedure*
- *Diphenhydramine – 50 mg PO (or IM or IV, if patient cannot take PO), one hour prior to the procedure (if blood pressure permits)*

Note: If clinician prefers, methylprednisolone 40 mg IV can be substituted for hydrocortisone 200 mg, dose for dose.

Source: RHC/JHE/EK 12/5/08

HOW TO PREMEDICATE for Pediatric Patient

Standard oral premedication regimen:

- *Prednisone – 0.5-0.7 mg/kg PO, 13, 7, and 1 hour prior to the procedure(50 mg maximum dose)*
- *Diphenhydramine –1.25 mg/kg PO 1 hour prior (50 mg maximum dose)*

Source: PJS 1/19/09

Please note: if a patient requires a steroid/benadryl prep, they will need to arrange for a driver to and from the appointment, due to the possibility of drowsiness from the required medication.