

RADIOLOGY REQUISITION

Routine **Urgent** **STAT**

Results Reporting
Location Code

Order Date: _____

ICD-9 codes (required): _____

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

Scheduling Exams - Call Center (734) 936-4500

Preps given at scheduling www.med.umich.edu/rad/preps/radloc.htm

Additional Imaging, including 3D, as indicated by Radiologist.

Notify me before additional imaging is performed.

Appt. Date: _____ Time: _____ Location: _____

Breast Imaging

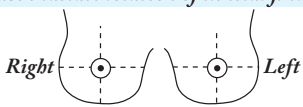
Screening Mammography Diagnostic Mammography

Procedures *Please indicate location of clinical finding*

Core Biopsy Fine Needle Aspiration

Wire Localization Breast Ultrasound

MR Breast Other: _____



Computed Tomography (CT)

Pre-exam Questionnaire: (submit with requisition)

[Click here for CT Questionnaire](#)

Cardiac: _____

CT Calcium Scoring (Symptomatic patient)

CT Calcium Scoring (Asymptomatic patient)

<input type="checkbox"/> Chest	<input type="checkbox"/> Renal Stone	<input type="checkbox"/> Neck (soft tissue)
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Bone Pelvis	<input type="checkbox"/> Cervical Spine
<input type="checkbox"/> Pelvis	<input type="checkbox"/> Facial Bone	<input type="checkbox"/> Thoracic Spine
<input type="checkbox"/> Pulmonary Embolism	<input type="checkbox"/> Orbit	<input type="checkbox"/> Lumbar Spine
<input type="checkbox"/> Head (Brain)	<input type="checkbox"/> Sinus	<input type="checkbox"/> Other: _____

Extremity _____:

CTA: _____ CT Urogram CT Enterography

Magnetic Resonance Imaging (MRI)

Pre-exam Questionnaire: (submit with requisition)

[Click here for MRI Questionnaire](#)

<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"/> Brain
<input type="checkbox"/> Pelvis (musculoskeletal)	<input type="checkbox"/> Neck (soft tissue)
<input type="checkbox"/> Extremity _____:	<input type="checkbox"/> Post Arthrogram
<input type="checkbox"/> MRA: _____	<input type="checkbox"/> IAC
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Pituitary/Sella

Ultrasound (US)

<input type="checkbox"/> Abdomen	<input type="checkbox"/> RUQ	<input type="checkbox"/> Kidney
<input type="checkbox"/> Obstetrical	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Testicular
<input type="checkbox"/> Aorta	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Carotids

Transvaginal w limited or complete abd and/or pelvis if indicated

Extremity _____: _____ Other: _____

Musculoskeletal, Neuro, Vascular Angio/Interventional (IR), Cross Sectional (CT & US) Interventional Procedures

Exam requested: _____

NAME
UMHS MRN
DOS
ACC

DOB
Sex

Research or Institutional Account: _____

Ordering Clinician (receives report):
Name: _____ UMHS Dr. Number _____

Attending Physician (if different than ordering):
Name: _____ UMHS Dr. Number _____

Patient Safety/Communications **Wheelchair**

Contrast Allergy **Any Severe Allergy** Asthma

Fall Precaution Interpreter needed: _____

11-55 y/o female (pregnancy testing may be offered/required)

Pregnancy test results: Negative Positive Date: _____

General Imaging - Plain Films (walk-in, no appointment necessary)

<input type="checkbox"/> Chest PA/LAT	<input type="checkbox"/> PA only	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Sacrum	<input type="checkbox"/> Skeletal Survey
<input type="checkbox"/> Skull (specify): _____	<input type="checkbox"/> Rib detail (specify): _____	
<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> T-Spine	<input type="checkbox"/> Lumbar Spine
<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Hip

Upper Extremity **Lower Extremity**

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

Gastrointestinal(GI)/Urinary Tract(GU)

<input type="checkbox"/> Esophagram	<input type="checkbox"/> Cystogram
<input type="checkbox"/> Enteroclysis	<input type="checkbox"/> Voiding Cystogram
<input type="checkbox"/> Small Bowel Follow Through	<input type="checkbox"/> IVP (Intravenous Pyelogram)
<input type="checkbox"/> Upper GI	<input type="checkbox"/> Hysterosalpingogram
<input type="checkbox"/> Contrast Enema	
<input type="checkbox"/> Swallowing Study (to coordinate with speech pathology-call 763-4003)	
<input type="checkbox"/> Other: _____	

Nuclear Medicine (NM)

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

The following patients will require premedication before receiving intravascular contrast 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.

THIS INCLUDES:

- 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

THIS DOES NOT INCLUDE THE FOLLOWING NON ALLERGIC REACTIONS:

- Vasovagal reaction
- Nausea
- Vomiting
- Contrast-induced renal dysfunction

2 Any severe allergic reaction to any substance (unless the patient has previously received contrast material without premedication and without a problem)

THIS INCLUDES:

- 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

THIS DOES NOT INCLUDE:

- Milder symptoms not listed at left, such as rash, hives or mild respiratory symptoms

3 For iodinated contrast only (CT, IR, IVP): Currently taking daily either two medications or a single combination agent for asthma.

In circumstances where premedication is required, consideration should 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 intravascular contrast, such as US or noncontrast CT/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 intravascular contrast within the Department of Radiology.

How to Premedicate an 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 exam; 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 intravascular 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 a 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/diphenhydramine (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.