



Diagnostic Imaging Outpatient Order Form

Lake Forest Hospital

Diagnostic Imaging

TEST RESULTS/QUESTIONS:
(847) 535-6300 TEL
lfh.org

APPOINTMENTS:
Call/fax according to contact
information on back

Thank you for referring your patient for Diagnostic Imaging services at Lake Forest Hospital. **Please give your patient a copy of this form to bring at time of service.**

In order to provide the best possible services to you and your patients, we request the following information. Please complete all fields to expedite your request.

<input type="checkbox"/> STAT
Call results to: _____
Fax results to: _____

PATIENT INFORMATION

_____	_____
Last Name	First Name
_____	_____
Date of Birth	

Home Phone Number	

Work/Cell Phone Number	

PHYSICIAN INFORMATION

Referring Practitioner Last Name	

First Name	

NPI #	Practitioner's Fax Number
_____	_____
Practitioner's Signature	Date
_____	_____

SIGNS & SYMPTOMS / DIAGNOSIS / ICD-9

When ordering multiple tests on the same order form, please indicate a sign, symptom, diagnosis or ICD-9 for each test/treatment. Do not include a "rule-out" diagnosis.

_____	_____
Breast	R L B
_____	_____
TMJ	WO W/WO
_____	_____
Other:	_____

NOTE: Tests in bold require advanced beneficiary notice at time of testing.

MRI and MRA

Patients over 60 years of age for MRI contrast exams require a Creatinine Lab test within 6 weeks of the MRI exam. Check below to order:

- Creatinine**
- Functional MRI
 - a. Motor
 - b. Language
 - c. Other
- Brain** WO W/WO
- Orbits** WO W/WO
- IAC** WO W/WO
- Pituitary** WO W/WO
- Cervical Spine** WO W/WO
- Thoracic Spine** WO W/WO
- Lumbar Spine** WO W/WO
- Neuro MRV**
- Body MRV**
 - a. SVC
 - b. IVC
 - c. Subclavian
- MRA** WO W/WO
 - a. Intracranial
 - b. Extracranial
 - c. Thoracic Aorta
 - d. Abdominal Aorta
 - e. Renal Artery
 - f. Celiac Artery
 - g. SMA
 - h. Peripheral UE/LE

- Cardiovascular MRI**
 - a. Morphology
 - b. Function (wall motion/EF)
 - c. Viability
 - d. Perfusion

- MRCP
- Neck Soft Tissue
- MRA Abdomen** WO W/WO
- Anterior Neck** WO W/WO
- Chest** WO W/WO
- Abdomen** WO W/WO
- Pelvis** WO W/WO
- Shoulder** R L B
- Elbow** R L B
- Wrist** R L B
- Hip** R L B
- Knee** R L B
- Ankle** R L B
- MR Arthrography of**

_____	_____
Breast	R L B
_____	_____
TMJ	WO W/WO
_____	_____
Other:	_____

Osteoporosis Screening

- Quantitative CT
- DEXA**
- Vertebral Fx Assessment
- Other: _____

Ultrasound

- Kidney/Bladder
- Renal
- Hip
- Abdomen
- Pelvis/Vag
- Hysterosonography
- Infant Hips
- Infant Spine
- OB 1st Trimester
- OB 2nd Trimester
- Obstetrical – Level 2
- OB Follow Up w/ Measurements
- Carotid Doppler
- Arterial Doppler Extremity
 - a. Upper
 - b. Lower
- Venous Doppler R L B
 - a. Upper
 - b. Lower
- Thyroid
- Scrotal
- Follicular
- Other: _____

PET Scan

- Lung Carcinoma**
- Lung–Single Pul. Nodule**
- Lung–Non–Small Cell**
- Lymphoma**
- Esophageal Carcinoma**
- Neurological**
- Colorectal Carcinoma**
- Head & Neck Carcinoma**
- Melanoma**
- Breast Cancer**
- Other: _____

Nuclear Medicine

- Thyroid I 123 Uptake & Scan
- Bone Scans
 - a. Routine – Whole Body
 - b. Triple Phase (With Flow Study)
 - c. With Spect
- Ceretec White Cell Scan
- MUGA Scan**
- HIDA Scan
- HIDA with CCK

Nuclear Medicine *continued*

- Gastric Emptying Scan
- Lung Scan–Vent & Perf
- I 131 Whole Body Thyroid
- Stress Thallium**
- Stress Thallium–pharmacological**
- Other: _____

CT and CTA

- Abdomen**WO W/WO
- NOTE: CT Abdomen only covers to iliac crest.
- Pelvis**WO W/WO
- Virtual Colonoscopy**
- Chest**WO W/WO
- Chest–Angio PE (IV Contrast Mandatory)**
- Sinus** Limited or Full
- Brain**WO W/WO
- Soft Tissue Neck**WO W/WO W
- Hip** R L B
- CT Angiography (CTA)**
 - a. Brain/Intracranial
 - b. Carotid & Vertebral Arteries
 - c. Coronary Artery
 - d. Pulmonary Arteries
 - e. Thoracic Aorta
 - f. Abdominal Aorta
 - g. Visceral
 - h. Renal Arteries
 - i. Lower Extremities
 - j. Upper Extremities

- Temporal Bones**
- Cervical Spine Level:** _____
- Thoracic Spine Level:** _____
- Lumbar Spine Level:** _____
- Shoulder**WO W/WO
 - R L B
- Elbow**WO W/WO
 - R L B
- Wrist**WO W/WO
 - R L B
- Hip**WO W/WO
 - R L B
- Knee**WO W/WO
 - R L B
- Ankle**WO W/WO
 - R L B
- Foot**WO W/WO
 - R L B
- CT Arthrography of**
- CT Enterography**
- Note: Abdomen w/wo and Pelvis w.
- Other: _____



Diagnostic Imaging Outpatient Order Form

test results/
questions 847 535 6300



Call/Fax for Appointments

- | | |
|--|--|
| <p>1 Lake Forest Hospital Campus
660 N. Westmoreland Road
Lake Forest, Illinois 60045
(847) 535-8000 phone
(847) 535-8001 fax</p> | <p>5 Gurnee – Brookside
36100 N. Brookside Drive
Suite LL-10
Gurnee, Illinois 60031
(847) 535-8000 phone
(847) 535-8001 fax</p> |
| <p>2 Grayslake Campus
1475 E. Belvidere Road (Rte. 120)
Grayslake, Illinois 60030
(847) 535-8000 phone
(847) 535-8001 fax</p> | <p>6 Gurnee – Tower Court
25 Tower Court, Suite A
Gurnee, Illinois 60031
(847) 249-3700 phone
(847) 249-4880 fax</p> |
| <p>3 Bannockburn
2151 Waukegan Road, Suite 150
Bannockburn, Illinois 60015
(847) 317-0011 phone
(847) 317-0022 fax</p> | <p>7 Libertyville
1800 Hollister Drive, Suite G-10
Libertyville, Illinois 60048
(847) 968-5300 phone
(847) 968-2400 fax</p> |
| <p>4 Glenview
2501 Compass Road, Suite 105
Glenview, Illinois 60026
(847) 535-8000 phone
(847) 535-8001 fax</p> | <p>8 Vernon Hills
870 W. End Court, Suite 102
Vernon Hills, Illinois 60061
(847) 535-8000 phone
(847) 535-8001 fax</p> |

main telephone 847 234 5600	website lfh.org
patient scheduling 847 535 8000	physician referral 847 535 6171