Brookings Health System
Central Scheduling
Phone: (605) 696-8888
Fax: (605) 696-8889

Date:_____
Clinic Chart #:_____

Patient Name: _____ **DOB:** _____

Detailed Symptoms:_____

Insurance: _____ **Policy #:** _____ **Auth#**_____

Insurance: _____ **Policy #:** _____ **Auth#**_____

Workcomp:%‰ %N Claim #:_____ **Date of Injury**_____

Priority of Exam: Emergency (___) *Please Fill Out the Below Emergency Contact Information* Next Available (___) Elective (___)

Emergency Call Back Information: _____

Allergies:_____

Patient Information Section

Phone#:_____
Alternative # _____
Alternative Name _____
(if minor or someone other than the patient)
Sex: €M € F Weight:_____
LMP:_____

Cat Scan

Contrast ‰Y or %N

□ Oral □ IV □ Both * □%Bun/Creat

Is the lab completed 72 hrs prior to exam?‰Y%N

If yes please send results; if no please order

- □ Head
- □ Chest PE
- □ Chest Routine
- □ Abdomen / Pelvis Routine
- □ Abdomen/ Pelvis - Acute/ Rule out Appy
- □ Kidney (Renal Stone Protocol)
- □ Bony Pelvis
- **Spine** □ Cervical □ Thoracic □ Lumbar
- □ Soft Tissue Neck
- □ PetScan Whole Body
- □ Intial □ Subsequent □ Subsequent KX
- □ PetScan Limited
- □ Subsequent Area □ Subsequent KX
- □ Other: _____

OPM

- □ IV Infusion □ Injection _____
- □ Wound Dressing Change
- □ Port Flush
- □ Transfusion-Type and Cross X ___ units
- □ Picc Line □ Insertion □ Removal
- □ Other: _____

Respiratory

- □ EKG
- □ Holter Monitor □ 24 hour □ 48 hour
- □ Event Monitor
- □ PFT □ PFT Complete Bronchodilator
- □ PFT Brochodilator □ PFT Complete
- □ Sleep Study □ Home Sleep Study (attach 2nd Form)
- □ Cardiolite - Stress Test
- □ Lexiscan Myocardial - Stress Test
- □ Exersice only - Stress Test
- □ Other: _____

Ultrasound

- □ Aortic Ultrasound
- □ AAA Screening
- □ Abdomen Limited / RUQ/ Gallbladder
- □ Abdomen Complete
- □ Breast □ R or □ L * previous mammo
  Date:_____ Facility _____
- □ Breast Biopsies □ R or □ L
  Pelvic □ TV □ TA (as indicated)
- □ Renal □ Renal Artery
- □ Thyroid
- □ Soft Tissue Neck
- □ OB □ > 14 weeks □ < 14 weeks
  □ TA & TV (as indicated)
  (OB) □ Follow up □ Limited □ 1st Screen
- □ Post Void Residual
- □ Venous Doppler □ R □ L □ Bilateral
- □ Carotid
- □ Echo
- □ ABI
- □ Other: _____

MRI

Contrast ‰ or %N

******Please Fill Out Screening Form******

If Yes to section A on the screening form, Creatinine & GFR labs will be needed within 6 weeks of scan date if constrast used

- * □ Creatinine & GFR
- □ Brain
- **Spine**
- □ Cervical □ Thoracic □ Lumbar
- □ Extremity □ R or □ L
- □ Knee □ R or □ L
- □ Shoulder □ R or □ L
- □ Foot □ R or □ L
- □ Ankle □ R or □ L
- □ Other: _____

Nuclear Medicine

- □ Three Phase Bone Scan
- □ Limited Bone Scan
- □ Total Body Scan
- □ I-123 Thyroid
- □ Hida Scan w/ cck
- □ Other: _____

X-ray

Abdomen
- □ KUB
- □ Flat & Erect
- □ Upper GI
- □ Small Bowel Series
- □ Esophagram / Barium Swallow
- □ Barium enema
- □ Air Contrast BE
- □ Other: _____

□ Chest
- □ PA or AP
- □ PA & Lat
- □ Other: _____

□ Skull/Facial Bones
- □ Skull-standard views
- □ Orbits-Pre MRI
- □ Sinus - standard views
- □ Facial Bones
- □ Other: _____

□ Spine
- □ Cervical
  - □ Lat only □ AP/Lat
  - □ AP/Lat/Obl □ Flex/Ext
- □ Thoracic
- □ Lumbar
  - □ Lat only □ AP/Lat
  - □ Ap/Lat/Obl □ Flex/Ext

□ Extremity
- □ Upper □ R □ L
- □ Specify: _____
- □ Lower □ R □ L
- □ Specify: _____

□ Pelvis
Other: _____

□ Video swallow/ Modified Barium Exam

□ DXA

□ Other: _____

Nutritional Order Form

Please complete the Separate Nutritional Order Form

LAB

* See Separate Lab Order Form

Additional Order Information:_____
_____

Primary Physician:_____ **Ordering Physician:** _____

Appt Date/ Time: _____ **Physician Signature:**_____