City of Hope® | ORANGE COUNTY

Radiology Scheduling
Phone: 949.671.4100
Fax: 949.777.6742

DIAGNOSTIC IMAGING Order Requisition

City of Hope Orange County Lennar Foundation Cancer Center
A CITY OF HOPE **NATIONAL MEDICAL CENTER FACILITY**
1000 FivePoint, Irvine, CA 92618

PATIENT INFORMATION

Last Name: _____

First Name: _____

DOB: ____ / ____ / ____ **Sex:** ☐ Male ☐ Female

Phone: _____

REQUIRED INFORMATION

Reasons for Exam/Diagnosis: _____

☐ **Routine** ☐ **STAT** **Date:** ____ / ____ / ____

Provider Phone: _____ **Ext:** _____ **Fax:** _____

Ordering Provider: _____

Provider Signature: _____

GENERAL X-RAY — *No Appointment Required*

- ☐ **Chest 2 View** (PA & LAT)
- ☐ **Abdomen 1 View** (KUB)
- ☐ **ABD Complete** (Include LLD Erect)
- ☐ **Abdomen Acute Series**
- ☐ **Bone Survey Complete**
- ☐ **Pelvis**
- ☐ **Spine Complete** (Chose below)
  - ☐C-Spine ☐T-Spine ☐L-Spine
- ☐ **Finger** ___ RT ___ LT
  - **Digit:** 1 2 3 4 5
- ☐ **Humerus** ____ RT ___ LT
- ☐ **Shoulder** ____ RT ___ LT
- ☐ **Forearm** ____ RT ___ LT
- ☐ **Elbow** ____ RT ___ LT
- ☐ **Hand** ____ RT ___ LT
- ☐ **Wrist** ____ RT ___ LT
- ☐ **Ribs** ____ RT ___ LT
- ☐ **Skull**
- ☐ **Sinuses**
- ☐ **Neck Soft Tissue**
- ☐ **Orbits** ____ RT ___ LT
- ☐ **Femur** ____ RT ___ LT
- ☐ **Knee** ____ RT ___ LT
- ☐ **Tibia/Fibula** ____ RT ___ LT
- ☐ **Ankle** ____ RT ___ LT
- ☐ **Foot** ____ RT ___ LT
- ☐ **Toe** ____ RT ____ LT **Digit:** 1 2 3 4 5
- ☐ **Other** (Specify) _____

FLUOROSCOPY — *Appointment Required*

- ☐ **UGI**
- ☐ **UGI & Small Bowel**
- ☐ **Small Bowel Series**
- ☐ **Contrast Enema**
- ☐ **Esophogram**
- ☐ **Lumbar Puncture**
- ☐ **Cystogram**
- ☐ **Other** (Specify) _____

ULTRASOUND — *Appointment Required*

- ☐ **Abdomen Complete**
- ☐ **Abdomen Limited**
- ☐ **Renal**
- ☐ **Carotid**
- ☐ **Pelvis Transabdominal & Transvaginal**
- ☐ **Pelvis Transabdominal**
- ☐ **Venous Doppler** (DVT)
  - ____ Lower ___ Upper
  - ____ RT ___ LT
- ☐ **Arterial Doppler Study**
  - ____ Lower ___ Upper
  - ____ RT ___ LT
  - ____ ABI (Ankle Brachial Index)
- ☐ **Soft Tissue:**
  - ☐Hernia
  - ☐Superficial Mass
- ☐ **Parathyroid**
- ☐ **Thyroid**
- ☐ **Other** (Specify) _____

City of Hope Orange County, Lennar Foundation Cancer Center supports Mammography services and Film Image Requests. For more information, please call Radiology Scheduling at 949.671.4100 or email at LFCCRadiologyScheduling@coh.org. We currently do not offer imaging services for pediatric patients.

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Provider Phone: _____ **Ext:** _____ **Fax:** _____

Ordering Provider: _____

Provider Signature: _____

CAT SCAN (CT) — *Appointment Required*

IV Contrast ☐ With ☐ Without | **HX of iodinated contrast allergy** ☐ Yes ☐ No **Specify Symptom:** _____

- ☐ **Brain**
- ☐ **Face**
- ☐ **Sinuses**
- ☐ **Medtronic Sinus Fusion**
- ☐ **Orbits**
- ☐ **IAC** (Temporal Bones)
- ☐ **Neck**
- ☐ **Chest**
- ☐ **Abdomen**
- ☐ **Pelvis**
- ☐ **Spine** (Choose below)
  - ☐ C-Spine ☐ T-Spine ☐ L-Spine
- ☐ **CT Angiography** (Choose below)
  - __ Coronary __ Neck
  - __ Brain __ Chest
  - __ Abdomen __ Pelvis
  - __ Run Off
- ☐ **Calcium Scoring**
- ☐ **Hips** ____ RT ____ LT
- ☐ **Extremity** ____ Lower ____ Upper ____ RT ____ LT
- ☐ **Other** (Specify) _____

MAGNETIC RESONANCE IMAGING (MRI) — *Appointment Required*

IV Contrast ☐ With ☐ Without | **HX of gadolinium contrast allergy** ☐ Yes ☐ No **Specify Symptom:** _____
History pacemaker or implanted cardiac device ☐ Yes ☐ No

- ☐ **Brain**
- ☐ **Face**
- ☐ **Orbits**
- ☐ **IAC**
- ☐ **Pituitary**
- ☐ **Chest**
- ☐ **Abdomen**
- ☐ **Pelvis**
- ☐ **Neck Soft Tissue**
- ☐ **Shoulder** __ RT ___ LT
- ☐ **Humerus** __ RT ___ LT
- ☐ **Forearm** __ RT ___ LT
- ☐ **Hand** __ RT ___ LT
- ☐ **Wrist** __ RT ___ LT
- ☐ **Elbow** __ RT ___ LT
- ☐ **Hip** __ RT ___ LT
- ☐ **Femur** ___ RT __ LT
- ☐ **Knee** ___ RT __ LT
- ☐ **Tibia/Fibula** ___ RT __ LT
- ☐ **Ankle** ___ RT __ LT
- ☐ **Foot** ___ RT __ LT
- ☐ **Spine** (Choose below)
  - ☐ C-Spine ☐ T-Spine
  - ☐ L-Spine
- ☐ **Breast**
- ☐ **Biopsy Breast**
  - ____ RT ___ LT
  - ____ Single Lesion
  - ____ Multiple Lesions
- ☐ **Prostate**
- ☐ **Other** (Specify) _____

MOLECUAR IMAGING/NUCLEAR MEDICINE — *Appointment Required*

☐ **PET-CT** (Specify) _____
☐ **FES** (Cerianna) **PSMA** (Select One) _____ F-18 ____ GA-68

Nuclear Medicine (Specify) _____
Other (Specify) _____

INTERVENTIONAL RADIOLOGY — *Appointment Required*

IR Scheduling Phone: 949.671.4070
Email: LFCCIRscheduling@coh.org

☐ **IR Consult** **Reason for Consult:** _____

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