

EASTERN RADIOLOGISTS, INC.
701 DOCTORS DRIVE, SUITE M, KINSTON, NC 28501
252-527-7077

PATIENT NAME: _____ AGE: _____ DATE OF BIRTH : _____

SYMPTOMS (Please identify for each study): _____

Fax Report to this number: _____ Call Report to this number: _____

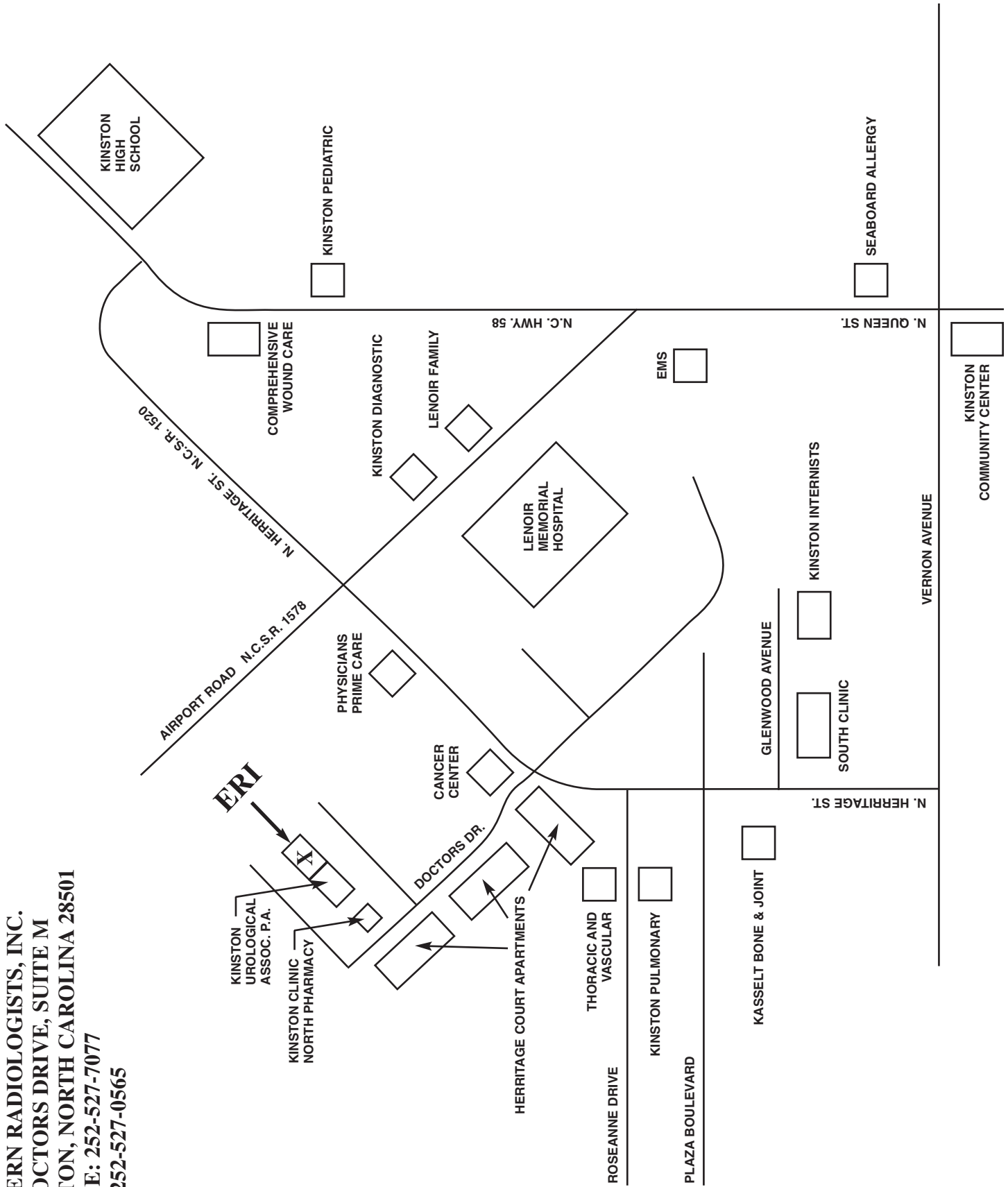
<p style="text-align: center;">CT SCAN</p> <p>CREATINE _____</p> <p>Date drawn _____</p> <p>(MUST HAVE IF OVER AGE 65 OR KNOWN RENAL DISEASE)</p> <p>PRIOR CT'S</p> <p>Facility _____</p> <p>Head</p> <p><input type="checkbox"/> w/o contrast</p> <p><input type="checkbox"/> w/wo contrast</p> <p><input type="checkbox"/> w/contrast if needed</p> <p><input type="checkbox"/> Temporal bone</p> <p>Sinuses</p> <p><input type="checkbox"/> Limited/screening</p> <p><input type="checkbox"/> Complete (coronal/axial)</p> <p><input type="checkbox"/> Orbit w/wo contrast</p> <p><input type="checkbox"/> Facial Bones</p> <p><input type="checkbox"/> Neck w/contrast</p> <p>Chest</p> <p><input type="checkbox"/> w/o contrast (contrast allergy)</p> <p><input type="checkbox"/> w/contrast</p> <p><input type="checkbox"/> w/o contrast (HRCT)</p> <p><input type="checkbox"/> PE protocol</p> <p>Abdomen</p> <p><input type="checkbox"/> w/wo contrast</p> <p><input type="checkbox"/> w/contrast</p> <p><input type="checkbox"/> Liver-Dynamics (3 phase)</p> <p>Abd/pelvic</p> <p><input type="checkbox"/> w/o contrast (stone sequence)</p> <p><input type="checkbox"/> w/wo contrast</p> <p><input type="checkbox"/> CT IVP Protocol</p> <p>Spine</p> <p><input type="checkbox"/> C-spine</p> <p><input type="checkbox"/> L-spine</p> <p>Orthopedic</p> <p><input type="checkbox"/> CT with reconstruction, Specify joint or area _____</p>	<p><input type="checkbox"/> Gallbladder</p> <p><input type="checkbox"/> Renal</p> <p><input type="checkbox"/> Renal/Bladder</p> <p><input type="checkbox"/> Bladder Only</p> <p>Pelvic</p> <p><input type="checkbox"/> Transvaginal w/Doppler if needed</p> <p><input type="checkbox"/> Transabdominal only</p> <p><input type="checkbox"/> Testicular with Doppler</p> <p>Obstetric</p> <p><input type="checkbox"/> 1st trimester</p> <p><input type="checkbox"/> 2nd trimester (anatomy)</p> <p><input type="checkbox"/> 3rd trimester (growth)</p> <p style="padding-left: 40px;"><input type="checkbox"/> with BPP</p> <p>Special US Procedures</p> <p><input type="checkbox"/> Hysterosonography</p> <p><input type="checkbox"/> Thyroid FNA</p>	<p style="text-align: center;">XRAYS continued</p> <p><input type="checkbox"/> Sternum</p> <p><input type="checkbox"/> Acute Abdominal Series</p> <p><input type="checkbox"/> Abdomen/KUB</p> <p><input type="checkbox"/> Pelvis</p> <p><input type="checkbox"/> Hips and Pelvis Rt Lt Bil</p> <p><input type="checkbox"/> Hip Rt Lt Bil</p> <p><input type="checkbox"/> Cervical Spine</p> <p><input type="checkbox"/> Thoracic Spine</p> <p><input type="checkbox"/> Lumbar Spine</p> <p><input type="checkbox"/> Sacrum Coccyx</p> <p><input type="checkbox"/> Femur Rt Lt Bil</p> <p><input type="checkbox"/> Knee Rt Lt Bil</p> <p><input type="checkbox"/> Tibia/Fibula Rt Lt Bil</p> <p><input type="checkbox"/> Ankle Rt Lt Bil</p> <p><input type="checkbox"/> Foot Rt Lt Bil</p> <p><input type="checkbox"/> Clavicle Rt Lt Bil</p> <p><input type="checkbox"/> Shoulder Rt Lt Bil</p> <p><input type="checkbox"/> Scapula Rt Lt Bil</p> <p><input type="checkbox"/> Elbow Rt Lt Bil</p> <p><input type="checkbox"/> Forearm Rt Lt Bil</p> <p><input type="checkbox"/> Wrist Rt Lt Bil</p> <p><input type="checkbox"/> Hand Rt Lt Bil</p> <p><input type="checkbox"/> Finger: specify _____</p> <p><input type="checkbox"/> Skull</p> <p><input type="checkbox"/> Facial Bones</p> <p><input type="checkbox"/> Mandible</p> <p><input type="checkbox"/> Nasal Bones</p> <p><input type="checkbox"/> Orbits</p> <p><input type="checkbox"/> Sinuses</p> <p><input type="checkbox"/> Other/special views: _____</p>
<p style="text-align: center;">ULTRASOUND</p> <p><input type="checkbox"/> Thyroid</p> <p>Abdomen</p> <p><input type="checkbox"/> Complete</p> <p><input type="checkbox"/> RUQ</p> <p><input type="checkbox"/> Aorta</p>	<p style="text-align: center;">BREAST IMAGING</p> <p><input type="checkbox"/> Screening Mammogram</p> <p><input type="checkbox"/> Diagnostic Mammogram R <input type="checkbox"/> L <input type="checkbox"/></p> <p style="padding-left: 40px;"><input type="checkbox"/> with ultrasound if needed</p> <p><input type="checkbox"/> Breast Ultrasound R <input type="checkbox"/> L <input type="checkbox"/></p> <p>Needle Localization</p> <p><input type="checkbox"/> by mammogram</p> <p><input type="checkbox"/> by ultrasound</p> <p><input type="checkbox"/> Ultrasound guided core biopsy</p> <p><input type="checkbox"/> Cyst Aspiration</p>	<p style="text-align: center;">DIAGNOSTIC XRAY</p> <p>Fluoro</p> <p><input type="checkbox"/> Barium Swallow</p> <p><input type="checkbox"/> Upper GI Series</p> <p><input type="checkbox"/> UGI-Small Bowel</p> <p><input type="checkbox"/> Small Bowel only</p> <p><input type="checkbox"/> Barium Enema</p> <p><input type="checkbox"/> Barium Enema with Air</p> <p><input type="checkbox"/> IVP</p> <p><input type="checkbox"/> Cystogram</p> <p><input type="checkbox"/> VCUG</p>
	<p style="text-align: center;">XRAYS</p> <p><input type="checkbox"/> Chest Pa and Lateral</p> <p><input type="checkbox"/> Chest 1 view</p> <p><input type="checkbox"/> Ribs Rt Lt Bil</p>	<p style="text-align: center;">Please fax requisition to: 252-527-0565.</p> <p style="text-align: center;">APPOINTMENT</p> <p>DATE: _____</p> <p>TIME: _____</p>

Physician Attestation: My signature below certifies that all of the above information is accurate and true to the best of my knowledge and that the medical necessity of the radiology exam(s) requested is supported by appropriate documentation.

Ordering Physician's Name (Please Print): _____ M.D./D.O.

Ordering Physician's Signature: X _____ M.D./D.O.

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KINSTON, NORTH CAROLINA 28501
PHONE: 252-527-7077
FAX: 252-527-0565



ERI

KINSTON UROLOGICAL ASSOC. P.A.
 KINSTON CLINIC
 NORTH PHARMACY

DOCTORS DR.

HERRITAGE COURT APARTMENTS

ROSEANNE DRIVE

KINSTON PULMONARY

PLAZA BOULEVARD

KASSELL BONE & JOINT

GLENWOOD AVENUE

SOUTH CLINIC

KINSTON INTERNISTS

SEABOARD ALLERGY

VERNON AVENUE

KINSTON COMMUNITY CENTER

KINSTON HIGH SCHOOL

KINSTON PEDIATRIC

COMPREHENSIVE WOUND CARE

KINSTON DIAGNOSTIC

LENOIR FAMILY

LENOIR MEMORIAL HOSPITAL

PHYSICIANS PRIME CARE

CANCER CENTER

THORACIC AND VASCULAR

N. HERRITAGE ST.

N.C. HWY. 58

N. HERRITAGE ST. N.C.S.R. 1520

AIRPORT ROAD N.C.S.R. 1578

N. QUEEN ST.