SaintFrancis Health System

# FAX REQUEST FOR FLUOROSCOPY / DIAGNOSTIC RADIOLOGY

905-029 / 01-21 **Preferred Location** _____

## DEMOGRAPHIC INFORMATION

| NAME OF OFFICE PERSONNEL REQUESTING | DATE | TIME | CONTACT NUMBER |
|---|---|---|---|
| | | | |

| ORDERING PHYSICIAN | PHYSICIAN PHONE NUMBER | PHYSICIAN FAX NUMBER |
|---|---|---|
| | | |

| PATIENT NAME IN FULL - *LAST NAME FIRST* | ☐ M ☐ F | AGE | BIRTH DATE | SOCIAL SECURITY NUMBER |
|---|---|---|---|---|
| | | | | |

| HOME PHONE NUMBER | WORK PHONE NUMBER | CELL / ALTERNATE NUMBER |
|---|---|---|
| | | |

## GUARANTOR INFORMATION - *IF DIFFERENT FROM PATIENT*

| GUARANTOR | GUARANTOR PHONE NUMBER |
|---|---|
| | |

## INSURANCE INFORMATION - *COPIES OF INSURANCE CARD FRONT AND BACK CAN BE SUBSTITUTED*

| INSURANCE NAME | POLICY HOLDER NAME |
|---|---|
| | |

| POLICY NUMBER / MEDICARE NUMBER | PRECERTIFICATION / AUTHORIZATION NUMBER |
|---|---|
| | |

## CLINICAL INFORMATION

We do not want to inconvenience your patient by calling them more times than necessary -

IF TESTS ARE BEING ORDERED FOR THIS PATIENT IN OTHER DEPARTMENTS - *PLEASE SUBMIT THE APPROPRIATE REQUEST FORM AND LIST HERE*

| SPECIAL NEEDS OF PATIENT | ALLERGIES |
|---|---|
| ☐ Wheelchair ☐ Other - | ☐ NKDA ☐ NKA |

| DIAGNOSIS CODES | ICD-10 CODE(S) | REASON FOR EXAM - ***PLEASE PROVIDE A DETAILED DESCRIPTION OF THE REASON FOR TEST INCLUDING SPECIFICITIES SUCH AS BODY SIDE, AREA OF INTEREST, SIGNS AND SYMPTOMS, ETC.*** |
|---|---|---|
| | | |

## PROCEDURES

**Weight limit is generally 500 pounds, some patients can be scheduled up to 600 pounds. If patient weight is between 501 and 600 pounds, we will advise if patient cannot be scheduled.**

☐ Barium Enema
- ☐ *Order Air Contrast*
- *Does the patient have an ostomy?* ☐ *Yes* ☐ *No*
- *If yes, will the procedure be through the ostomy?* ☐ *Yes* ☐ *No*
- *Provide patient with a copy of the Adult Bowel Cleansing Preparation if appropriate.*

☐ Cystogram

☐ Dysphasiagram with Speech Pathology (Modified Barium Swallow)

☐ Esophagram - *Type: Routine, Gastro Esophagus, Water Soluble Esophagus*

*Aka: Barium Swallow, Dysphagiagram without speech, Esophagus Video, Pharynx Video*

☐ Fistulagram

☐ Water Soluable Enema
- *Does the patient have an ostomy?* ☐ *Yes* ☐ *No*
- *If yes, will the procedure be through the ostomy?* ☐ *Yes* ☐ *No*
- *Provide patient with a copy of the Adult Bowel Cleansing Preparation if appropriate.*

☐ Gastrostomy Tube Check

☐ Hysterosalpingogram (HSG) *Aka: Ureterosalpingogram*
- *Does the patient have a prescription for Doxycline 100 mg or Z-Pak?*
- ☐ *Yes* ☐ *No* *(answer is required)*

*Start date of menstrual cycle:*_____

☐ Loopogram

☐ Pouchogram

☐ Small Bowel Follow Through

☐ SNIFF Test (Fluoroscopy of Diaphragm)

☐ T-Tube Cholangiogram

☐ Upper GI
- *Does the patient have a feeding tube?* ☐ *Yes* ☐ *No*
- ☐ *Water Soluble*
- ☐ *With Air Contrast*

☐ Upper GI with Small Bowel Follow Through
- *Does the patient have a feeding tube?* ☐ *Yes* ☐ *No*
- ☐ *Water Soluble*

☐ Urethrogram

☐ Voiding Cystourethrogram -
- *Is there a Foley Catheter in place?* ☐ *Yes* ☐ *No*
- *DC the catheter at end of procedure?* ☐ *Yes* ☐ *No*

☐ Intravenous Pyelogram (IVP) -
*This procedure includes a KUB. This test is always with contrast iodine. If patient has an allergy to contrast iodine, the ordering provider should pre - medicate the patient. A Creatinine is required if the patient is 60 years of age or older or has a history of diabetes, renal or kidney disease, or has one kidney*

*Creatinine:*_____ *Date of Lab:*_____

*Provide patient with a copy of the Adult Bowel Cleansing Preparation.*

| AREA OF INTEREST | COMMENTS |
|---|---|
| | |

**May this order be modified to comply with established Saint Francis Health System imaging protocols?** ☐ **Yes** ☐ **No**

| PHYSICIAN - *SIGNATURE* | DATE | TIME |
|---|---|---|
| | | |



**FAX TO CENTRAL SCHEDULING AT 918-494-1885**