Imaging Outpatient Request

HAWAIʻI PACIFIC HEALTH | STRAUB MEDICAL CENTER
CREATING A HEALTHIER HAWAIʻI

Scheduling: 808-522-4221 | Scheduling Fax: 808-522-4240

Patient Name _____
Date of Birth _____ Home Phone_____ Work Phone _____

CT

- ☐ CT ABDOMEN AND PELVIS; WITH CONTRAST
- ☐ CT CHEST-ABDOMEN-PELVIS; WITH CONTRAST
- ☐ CT ABDOMEN AND PELVIS; WITHOUT CONTRAST
- ☐ CT CHEST WITHOUT CONTRAST
- ☐ CT HEAD WITHOUT CONTRAST
- ☐ Other: _____

DIAGNOSIS/Clinical History: _____

MRI

- ☐ MR BRAIN WITHOUT CONTRAST
- ☐ MR EXTREMITY (LOWER) JOINT WITHOUT CONTRAST
- ☐ MR SPINE (LUMBAR) WITHOUT CONTRAST
- ☐ Other: _____
- ☐ MR BRAIN WITHOUT & WITH CONTRAST
- ☐ MR BRAIN + MRA BRAIN WITHOUT CONTRAST
- ☐ MR SPINE (CERVICAL) WITHOUT CONTRAST

DIAGNOSIS/Clinical History: _____

XRAY

- ☐ XR CHEST, SINGLE VIEW
- ☐ XR CHEST, 2 VIEWS
- ☐ XR ABDOMEN, 1 VIEW
- ☐ XR KNEE, 3 VIEWS
- ☐ XR FOOT, 3+ VIEWS
- ☐ XR SHOULDER, 2+ VIEWS
- ☐ Other: _____

DIAGNOSIS/Clinical History: _____

US

- ☐ US ABDOMEN, LIMITED
- ☐ US TRANSVAGINAL/PELVIC
- ☐ US ABDOMEND COMPLETE
- ☐ US SOFT TISSUE HEAD/NECK
- ☐ US BREAST UNILATERAL
- ☐ Other: _____

DIAGNOSIS/Clinical History: _____

NUCLEAR MEDICINE

- ☐ NM BONE &/OR JOINT; WHOLE BODY
- ☐ NM HEPATOBILIARY W/GALLBLADDER
- ☐ NM TUMOR LOCALIZATION
- ☐ NM PULMONARY VENT AND PERFUSION
- ☐ NM GASTRIC EMPTYING STUDY
- ☐ Other: _____

DIAGNOSIS/Clinical History: _____

Copy of Report to: _____

Physician: _____ Phone Number: _____

Ordering Physician's signature _____ Date: _____ Time: _____

DECISION SUPPORT VENDOR: _____ **DECISION SUPPORT SESSION ID:** _____

DECSION SUPPORT ADHERENCE: _____ ___ **DECSION SUPPORT SCORE:** _____

SPECIAL INSTRUCTIONS/COMMENTS: