BEST PHONE NUMBER FOR PATIENT DURING DAYTIME HOURS _____

Outpatient Diagnostic Form

Please bring this form with you to WCCH when presenting for test

NAME: _____ **Date of Birth:** _____

Symptom(s): OR Diagnosis (REQUIRED): _____

_____

PCP: _____ **Referred By:** _____

RADIOLOGY TESTS	ULTRASOUND	WOMEN OUTPATIENT IMAGING CENTER
THIS IS NOT A COMPLETE	Rt. Upper Quad./GB	**MAMMOGRAPHY**
LIST OF TESTS. PLEASE	Abdominal Complete	Screening Mammo Diagnostic if needed
CONTACT THE APPROPRIATE	Pelvic	Diagnostic with ultrasound if indicated
DEPARTMENT IF YOU NEED	OB	Bone Density
FURTHER ASSISTANCE.	Renal and Bladder	**MRI**
NOTE: Specify LEFT or RIGHT	Aorta	Head
on extremities.	Breast RT LT	Cervical Spine
Clinical information should be	Thyroid	Thoracic Spine
specific to the exam ordered.	Echo – doppler study	Lumbar Spine
Chest PA/LAT	Carotids – doppler study	Shoulder RT LT
Abdomen (KUB)	Venous – doppler study	Knee RT LT
Abdomen series w/ PA Chest	Left Arm Right Arm	**OTHER**
Ribs w/ PA Chest RT LT	Left Leg Right Leg	
Cervical Spine	**OTHER**	**CARDIOPULMONARY TESTS**
Thoracic Spine		EKG
Lumbar Spine		Holter Monitor 24/48 hours
Sacrum/Coccyx	**CT**	**PFT**
Pelvis	Head	Spirometry pre-bronchodilator
Hip RT LT	Sinuses	Spirometry post-bronchodilator
Knee RT LT	Neck (soft tissue)	DLCO (Diffusion)
Ankle RT LT	Chest	N_2 Washout (FRC)
Foot RT LT	Chest for PE	**STRESS TEST - Choose 1 From Each Category**
Shoulder RT LT	Abdomen/Pelvis	**Type of Stress** / **Imaging with Test**
Forearm RT LT	Urinary Tract for Stones (NO CONTRAST)	☐ Treadmill (exercise) / ☐ None
Wrist RT LT	**OTHER**	☐ Persantine (non-exercise) / ☐ Echo (stress echo)
Hand RT LT		☐ Dobutamine (non-exercise) / ☐ Cardiolite (nuclear)
Sinuses		**OTHER**
UGI	**NUCLEAR MEDICINE**	
Barium Enema	Bone - Whole Body	
IVP	Bone - 3 Phase	
BA Swallow	Renal MAG 3	
OTHER	Lung (Vent. & Perf.)	
	GI Bleed	**APPOINTMENTS**
BONE DENSITY	Thyroid	DATE: _____
	Hepatobiliary w/ Ejection Fraction	TIME: _____
	Gastric Emptying	DATE: _____
	OTHER	TIME: _____

Physician/Physician Assistant/Nurse Practitioner Signature: _____ _____

(required) **Date & Time**

FAX THIS FORM TO: 276-228-6887

To Schedule/Reschedule Test Call: 276-625-8829

_____

PRINT PRACTITIONER NAME

Patient Information/Label

Wythe County Community Hospital

W.ORDER NUR-1154 RV 06/2013 1st White - WCCH 2nd White - Physician