KNOXVILLE Hospital & Clinics

An Affiliate of MERCYONE

Radiology Order Sheet

Date: ________

Date of Service ________

Pt Insurance information:

	Medicare
	Medicaid
	Private Ins

Patient Name ______________________________

Patient DOB: ______________________________

Acute Symptoms/diagnosis codes:

Physician Signature:

General X-Ray

	Chest	
	Abdomen	
	Pelvis	
	Ribs	R or L
	C-Spine	
	T-Spine	
	L-Spine	
	Hip	R or L
	Femur	R or L
	Knee	R or L
	Tibia/Fibia	R or L
	Ankle	R or L
	Foot	R or L
	Toes	R or L
	Clavicle	R or L
	Scapule	R or L
	Shoulder	R or L
	Humerus	R or L
	Elbow	R or L
	Forearm	R or L
	Wrist	R or L
	Hand	R or L
	Fingers	R or L
	Sinuses	
	Facial Bones	
	Barium Swallow	

CT

	Head	
	Sinuses	
	Neck	
	Chest	
	Chest for PE	
	Abdomen	
	Pelvis	
	Upper Extremity	R or L
	Lower Extremity	R or L
	Carotid CTA	
	Renal CTA	
	Brain CTA	
	C-Spine	
	T-Spine	
	L-Spine	
	Without contrast	
	With Contrast	
	With and without	

MR

	Head	
	C-Spine	
	T-Spine	
	L-Spine	
	Shoulder	R or L
	Hip/Pelvis	R or L
	Knee	R or L
	Ankle	R or L
	Foot	R or L
	Abdomen	
	Carotid MRA	
	Brain MRA	
	Renal MRA	
	Without contrast	
	With and without	

Ultrasound

	Abdomen
	Limited Abdomen
	Breast
	Carotid Duplex
	Pelvis
	Scrotum
	Thyroid

	RLE Venous Duplex
	LLE Venous Duplex
	RUE Venous Duplex
	LUE Venous Duplex
	BLE Venous Duplex
	BUE Venous Duplex

Other: ____

PAR information: ____

**** **Please send patient demographic information** ****