JOHN MUIR HEALTH | UCSF Health

Berkeley Outpatient Center Imaging
3100 San Pablo Ave, 3rd Floor, Berkeley CA 94702
Scheduling: 510.985.5030 • Fax: 415.353.7299

Creatinine: _____ Date: _____
Pregnancy: ☐Yes ☐No
Prior Contrast Reaction: ☐Yes ☐No
Impaired Renal Function: ☐Yes ☐No

PATIENT APPOINTMENT
Date: _____
Time: _____
Location: _____
STAT REQUEST: ☐Yes ☐No

BERKELEY OUTPATIENT CENTER IMAGING ORDER FORM

Patient Information:

Patient Name: _____ Date of Birth: ____/____/____ UCSF MRN (if available): _____
Home Phone: _____ Cell Phone: _____

Referring Physician Information:

Physician Name: _____ Office Contact Person: _____
Phone: _____ Cell Phone: _____ Fax: _____
Diagnosis/Clinical Indications: _____
MD Signature Required: _____

Exam Requested: *Please check box carefully for requested study and complete required sections below.*

☐MRI

Contrast ☐Yes ☐No

MR Neuroradiology & ENT
☐ Brain
☐ Brain Lab
☐ w/fiducials
☐ w/o fiducials
☐ Nasopharynx (w/Neck)
☐ Stereotactic Brain
☐ Stealth Brain
☐ Internal Auditory Canal
☐ Pituitary
☐ TMJ
☐ Orbits
☐ Sinus

MR Spine
☐ Cervical Spine
☐ Thoracic Spine
☐ Lumbar Spine
☐ Total Spine
☐ Neurogram

MR Vascular
☐ Intracranial MRA
☐ Cervical Carotids/ Neck MRA

MR Body
☐ Full Body
☐ Abdomen
☐ Pancreas
☐ Liver
☐ Pelvis
☐ Breast
☐ Right ☐ Left
☐ Mass ☐ Leak
☐ TMJ
☐ Prostate

Chest/Cardiac
☐ Chest
☐ Thyroid
☐ Parathyroid
☐ Cardiac MRI

MR Body MRA
☐ MRA Abdomen
☐ MRA Thoracic
☐ Renal MRA
☐ Lower Extremity w/Runoff
☐ Other:_____

MR Musculoskeletal
☐ **Right** ☐ **Left**
☐ Shoulder
☐ Elbow
☐ Wrist
☐ Hand
☐ Finger
☐ Hip
☐ Knee
☐ Ankle
☐ Foot

☐CT

Contrast ☐Yes ☐No

CT Neuroradiology & ENT
☐ Brain
☐ Orbits
☐ Temporal Bone
☐ Neck
☐ Maxillofacial
☐ Sinus
☐ CT Angiogram
☐ SAH
☐ Stroke

CT Spine
☐ Cervical Spine
☐ Thoracis Spine
☐ Lumbar Spine

CT Body
☐ Chest
☐ Abdomen
☐ Pelvis
☐ CTA Abd/Pel
☐ Renal Donor
☐ Liver Donor

CT Miscellaneous
☐ Bilateral lower extremity runoff

☐X-Ray

X-Ray Thorax
☐ Chest 2 Views
☐ Ribs
☐ Sternum
☐ Clavicle
☐ Sterno-clavicular Joints
☐ AC Joints
☐ Abdomen

X-Ray Spine
☐ Cervical Spine
☐ Thoracic Spine
☐ Thoracolumbar Spine
☐ Lumbar Spine
☐ Sacrum/Coccyx
☐ Scoliosis Series
☐ Pelvis

X-Ray Lower Extremity
☐**Right** ☐**Left** ☐**Bilat**
☐ Hip
☐ Femur
☐ Knee
☐ Tibia/Fibula
☐ Ankle
☐ Foot
☐ Heel
☐ Toe
☐ Hip-to-Ankle

X-Ray Upper Extremity
☐**Right** ☐**Left**
☐**Bilat**
☐ Shoulder
☐ Humerus
☐ Elbow
☐ Forearm
☐ Wrist
☐ Hand
☐ Finger

X-Ray Head
☐ Skull
☐ Facial Bones
☐ Nasal Bones
☐ Orbits
☐ Mandible

X-Ray Misc. Exams
☐ Bone Survey
☐ Myeloma
☐ Metabolic
☐ Pediatric
☐ Bone Age
☐ Shunt Series
☐ Other: _____

☐DEXA

☐**DEXA Bone Density Scan**

☐ULTRASOUND

US Abdomen
☐ Abdomen complete
☐ Abdomen w/Doppler
☐ Pre-Liver Transplant
☐ Post-Liver Transplant
☐ Renal/Bladder only
☐ Kidney Transplant

US OB/GYN
☐ Pelvis (Uterus & Ovaries)
☐ Pelvis w/transvaginal imaging
☐ First Trimester OB
☐ singleton

US Superficial Structures
☐ Thyroid/Parathyroid
☐ Scrotum

US Vascular
☐ Venous (DVT): Upper Extremity
☐ **Right** ☐**Left** ☐**Bilat**

US Miscellaneous
☐ Soft tissue-give location:_____
☐ Other:

☐PET/CT

Please specify one:
☐ Initial Treatment Strategy ☐ Subsequent Treatment Strategy
☐ **PETCT FDG VERTEX TO MID THIGH (NON-DIAGNOSTIC CT)** - If no additional CT is required.
☐ **PETCT FDG VERTEX TO TOES (NON-DIAGNOSTIC CT)** - If no additional CT is required.
☐ **PETCT Vertex to Mid-Thigh** – If additional Diagnostic CTs are needed:
☐ Neck ☐ Chest ☐ Abd/Pelvis ☐ Lower Extremities ☐ Upper Extremities | ☐ **With Contrast** ☐ **Without Contrast**
☐ **PETCT Vertex to Toes** – If additional Diagnostic CTs are needed:
☐ Neck ☐ Chest ☐ Abd/Pelvis ☐ Lower Extremities ☐ Upper Extremities | ☐ **With Contrast** ☐ **Without Contrast**
(CT without IV contrast because of medical contraindication to IV contrast)

Please note: *If your patient requires anesthesia, please call 415.353.7900 to schedule at the UCSF Mission Bay or Parnassus locations.*