ALLIANCE COMMUNITY HOSPITAL
Experience Health Caring

200 East State Street
Alliance, Ohio 44601
Scheduling:330-596-7187
Imaging: 330-596-7700

IMAGING DEPARTMENT

Patient: _____ Birthdate: _____ Age: _____
Weight: _____ Height: _____
Scheduled/ Requested Date: _____
Time: _____
Symptoms: _____
_____
Precert#: _____

Physician: _____
Stat [ ] Routine [ ] PreOp [ ]
Allergies: No [ ] Yes [ ] _____
Contrast Allergies No [ ] Yes [ ] _____
Diabetic [ ] If yes, specify meds: _____
_____
_____

CT ORDERS (LONG)

X	Head	X	Spine
	Circle one		Cervical
	w/o & w OR w/o OR w		Thoracic
	Attn:		Lumbar
	Brain		
	Orbits		**CTA Cardiac / Chest w/o & with**
	Facial Bones		* note: patient needs sperate order for
	Sinuses		Lopressor and sublingual Nitro
	Neck		**CTA Carotids**
	Circle one		
	w/o & w OR w/o OR w		**CTA Runoff**
	Chest		**Extremities**
	Circle one		Circle One: Left or Right
	w/o & w OR w/o OR w		Specify Region of Interest:
	Abdomen / Pelvis		
	Circle one		
	w/o & w OR w/o OR w		
	Chest / Abdomen / Pelvis		
	Circle one		
	w/o & w OR w/o OR w		
	Bony Pelvis w/o		