gillette CHILDREN'S

To schedule call: 651-290-8707
Please complete and fax to: 651-726-2622

Patient Name: _____ Date of Birth: _____

Parent / Guardian: _____ Phone Number: _____

Appt. Preference: ☐ Today ☐ Within 1 week ☐ Specify, within: _____ weeks/months

Reason for Exam / Medical Necessity / Symptoms & Duration: _____

Dx (All indications): _____

SPINE	Views	Specify	With Lift	If Brace
☐Full Spine	PA AP Lat Obl	Standing Recumbent Sitting in WC Sitting out of WC	Right Left _____cm	In brace Out of brace
☐Traction Spine				
☐Cervical	AP Lat Obl Flex Ext Dens Swimmers	Standing Recumbent Sitting in WC Sitting out of WC		In collar Out of collar
☐Thoracic ☐ ThoracoLumbar	AP Lat Obl Flex Ext Side Bending	Standing Recumbent Sitting in WC Sitting out of WC		In brace Out of brace
☐Lumbar	AP Lat Obl Flex Ext Spot L5-S1 Side Bending	Standing Recumbent Sitting in WC Sitting out of WC		In brace Out of brace

PELVIS	Views	Specify	If Cast	If Brace
☐Pelvis	AP	Standing Recumbent Dangling	On Off	In brace Out of brace With Lift
☐Frog Pelvis	(AP Bilateral Frog Hips)			
☐Hip	AP Judet Frog Lat XTable Lat False Profile	Bilat Right Left		

LOWER Ext	Views	Specify	If Cast	Specify
☐Scanogram Leg Length		☐Bone Age	Right Left	
☐Full Lower Extremity	AP Lat	Bilat Right Left Standing Recumbent	On Off	With Lift Right Left _____cm
☐Femur	AP Lat Obl	Bilat Right Left	On Off	
☐Knee	AP Lat Obl Sunrise Tunnel	Bilat Right Left Max Extension	On Off	Standing Supine
☐Tibia Fibula	AP Lat Obl	Bilat Right Left Max Extension	On Off	AFOs On Off
☐Ankle	AP Lat Mortise Distal Tib/Fib	Bilat Right Left	On Off	Standing Supine
☐Foot	AP Lat Obl	Bilat Right Left Standing	On Off	AFOs On Off
☐Toe specify digit __	AP Lat Obl	Bilat Right Left	On Off	

Other Exam Requested or Further Instructions:

UPPER Ext	Views	Specify	If Cast
☐Shoulder	AP Lat Y view Axillary Grashey	Bilat Right Left	
☐Clavicle	AP AP 20° up angle	Bilat Right Left	
☐Scapula	AP Lat Y view	Bilat Right Left	
☐Humerus	AP Lat	Bilat Right Left	On Off
☐Elbow	Distal Humerus AP Lat Obl Proximal Forearm	Bilat Right Left	On Off
☐Forearm	AP Lat	Bilat Right Left	On Off
☐Wrist	PA Lat Obl Scaphoid	Bilat Right Left	On Off
☐Hand	PA Lat Obl	Bilat Right Left	On Off
☐Finger(s) specify digit _____	AP Lat Obl	Bilat Right Left	On Off
☐Scanogram Upper Extremity			
☐Full Upper Ext.	AP Lat	Bilat Right Left	On Off

MISC	Views	Specify	
☐Shunt Series	☐ Shunt Valve		
☐ Skull	AP Towne Rt Lat Lt Lat		
☐Bone Age Hand		Right Left	
☐Bone Age Hemiskeleton		Right Left	
☐Skeletal Survey			
☐Chest	PA AP Lat	Upright Recumbent Decubitus	
☐Abdomen / KUB	AP Lat Pump Series	Upright Recumbent Decubitus	

Provider Name: _____ **Signature:** _____ **Date**: _____ **Time:** _____
Print/ Stamp here

Phone Number: _____ **Address:** _____

0118-902
01/11, 11/11, 9/15

Outside Provider Radiology Order