DEPARTMENT OF RADIOLOGY
Imaging Exam Requisition

PATIENT NAME (Last) ______________________ (First)______________________ DOB ____/____/____ SEX________

PATIENT PHONE# ______________________ DIAGNOSIS **(Required)** ______________________________

*Reason for exam should establish medical necessity and may include signs, symptoms or abnormal test results

We CANNOT accept "Rule Out", "Probable", "Possible", "Suspected", "Questionable", "Follow-UP" or Diagnosis Codes

EXAM REPORTS/RESULTS

______ Routine ________ STAT ______ **Hold and Call Report** Phone (______)__________________ Fax (______)__________________

PHYSICIAN **SIGNATURE (Required)**__________________________________ Date **(Required)** ______/_______/________

EXAM REQUESTED: Please check box carefully for requested study and complete required section(s) below.

No Appointment Needed

GENERAL X-RAY

- ☐ CHEST 2 VIEW (PA & LAT)
- ☐ ABDOMEN 1 VIEW (KUB)
- ☐ ABD COMPLETE (Include LLD Erect)
- ☐ ABDOMEN ACUTE SERIES
- ☐ SHUNT SERIES
- ☐ BONE AGE STUDIES
- ☐ BONE SURVEY COMPLETE
- ☐ BONE HEMISKELETON (24mos. and under)
- ☐ NECK SOFT TISSUE
- ☐ SPINE COMPLETE (*Choose Below*)
  ____ C-SPINE ____ T-SPINE ____ L-SPINE
- ☐ SPINE THORACOLUMBAR (Scoliosis)
- ☐ FINGER __RT __LT Digit: 1 2 3 4 5
- ☐ HAND ____RT ____ LT
- ☐ WRIST ____ RT ____ LT
- ☐ FOREARM ____ RT ____ LT
- ☐ ELBOW ____ RT ____ LT
- ☐ HUMERUS ____RT ____ LT
- ☐ SHOULDER ____RT ____ LT
- ☐ RIBS ____RT ____ LT
- ☐ SKULL
- ☐ SINUSES
- ☐ TOE __RT __LT Digit: 1 2 3 4 5
- ☐ FOOT ____RT ___ LT
- ☐ ANKLE ____RT ___ LT
- ☐ TIBIA/FIB ____RT ___ LT
- ☐ KNEE ____RT ___ LT
- ☐ FEMUR ____RT ___ LT
- ☐ HIP BILAT w/PELVIS
- ☐ PELVIS ___ 1 VIEW ___ 2 VIEW
- ☐ BILAT STANDING LOWER EXTREMITY
- ☐ SCANOGRAM BONE LENGTH
- ☐ OTHER (*Specify*)__________________

Scheduled Appointment Required

FLUOROSCOPY- Must be scheduled

- ☐ UGI
- ☐ UGI and SMALL BOWEL
- ☐ SMALL BOWEL SERIES
- ☐ RETROGRADE VCUG
- ☐ CONTRAST ENEMA
- ☐ ESOPHOGRAM
- ☐ DYSPHAGIA
- ☐ OTHER (*Specify*)__________________
- ☐ LUMBAR PUNCTURE
  ___ with Anesthesia ___ without Anesthesia
- ☐ FL ARTHROGRAM (*Specify*)
  Site __________________ Side______

ULTRASOUND- Must be scheduled

- ☐ ABDOMEN COMPLETE
- ☐ ABDOMEN LIMITED
- ☐ DUPLEX DOPPLER COMPLETE
- ☐ DUPLEX DOPPLER LIMITED
- ☐ RENAL
- ☐ AORTA ☐ IVC DOPPLER
- ☐ CRANIAL
- ☐ THYROID
- ☐ HEAD & NECK SOFT TISSUE
- ☐ PYLORUS
- ☐ HIPS: ___ STATIC ___ DYNAMIC
- ☐ PELVIS
- ☐ TESTICULAR
- ☐ VENOUS DOPPLER STUDY____________
- ☐ ARTERIAL DOPPLER STUDY____________

COMPUTED TOMOGRAPHY (CT)- Must be scheduled

- ☐ BRAIN
- ☐ FACE
- ☐ SINUSES
- ☐ MEDTRONIC SINUS FUSION
- ☐ ORBITS
- ☐ IAC (TEMPORAL BONES)
- ☐ NECK
- ☐ CHEST
- ☐ ABDOMEN
- ☐ PELVIS
- ☐ SPINE (*Choose Below*)
  ____ C-SPINE ____ T-SPINE ____ L-SPINE
- ☐ HIPS: ___ RT ___ LT
- ☐ EXTREMITY ____RT ____LT ____BILAT
- ☐ CT ANGIOGRAPHY (*Choose Below*)
  ___ Coronary ___ Neck
  ___ Brain ___ Chest
  ___ Abdomen ___ Pelvis
- ☐ OTHER (*Specify*)__________________

I.V.Contrast? ____ With ____ Without **Anesthesia Needed?** ____ Yes ____ No

MAGNETIC RESONANCE IMAGING (MRI)- Must be scheduled

- ☐ HEAD ☐ ORBITS
- ☐ PITUITARY ☐ IAC'S
- ☐ NECK ☐ FACE
- ☐ ABDOMEN ☐ PELVIS
- ☐ HAND ____ RT ____LT ____BILAT
- ☐ WRIST ____ RT ____LT ____BILAT
- ☐ ELBOW ____ RT ____LT ____BILAT
- ☐ FOREARM ___RT ____LT ____BILAT
- ☐ HIP ___ RT ____LT ____BILAT
- ☐ FEMUR ____ RT ____LT _____BILAT
- ☐ KNEE ____ RT ____LT _____BILAT
- ☐ TIB/FIB ____ RT ____LT _____BILAT
- ☐ ANKLE ____ RT ____LT _____BILAT
- ☐ FOOT ____ RT ____LT _____BILAT
- ☐ SHOULDER ____ RT ____LT _____BILAT
- ☐ HUMERUS ____ RT ____LT _____BILAT
- ☐ SPINE (*Choose Below*)
  ____C-SPINE ____T-SPINE ____L-SPINE
- ☐ MR ANGIOGRAPHY (*Choose Below*)
  ___ NECK ___ HEAD
  ___ CHEST ___ ABDOMEN
  ___ PELVIS
  ___ UPPER EXTREMITY
  ___ LOWER EXTREMITY
- ☐ MR ARTHROGRAM (*Specify*)
  Site __________________ Side______
- ☐ OTHER (*Specify*)__________________

I.V.Contrast? ____ With ____ Without ____ Without & With **Anesthesia Needed?** ____ Yes ____ No

NUCLEAR MEDICINE (NM)- Must be scheduled

- ☐ GENERAL NUCs:________________
- ☐ PET CT: __________________
- ☐ OTHER (Specify)__________________

Scheduling # 888-770-CHOC (2462) **Scheduling Fax # 844-890-2297**

For additional information: www.choc.org/programs-services/radiology

CHOC Children's

1201 W La Veta, Orange, California 92868 (714) 997-3000

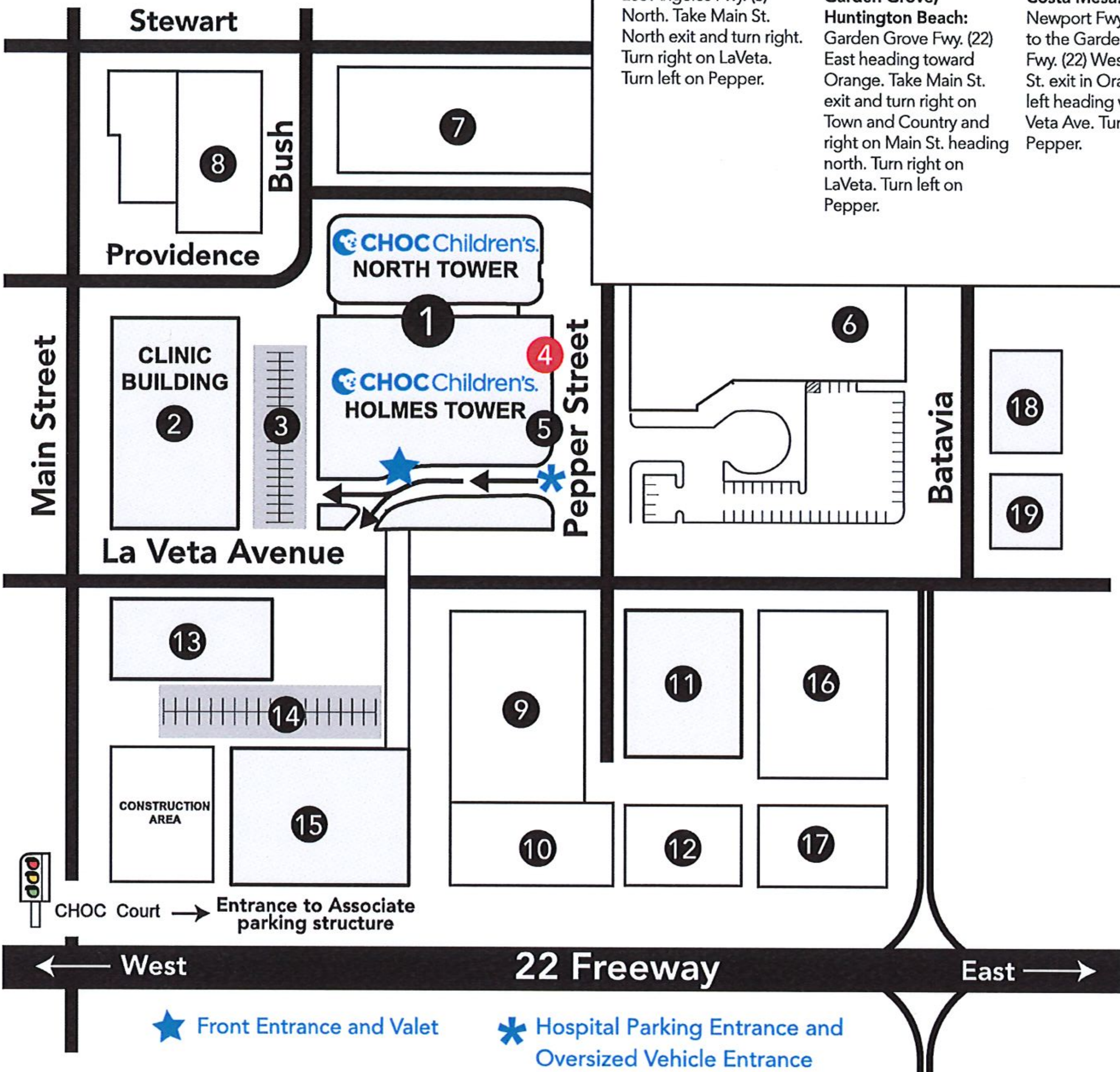
From South County: Los Angeles Fwy. (5) North. Take Main St. North exit and turn right. Turn right on LaVeta. Turn left on Pepper.

From Westminster, Garden Grove, Huntington Beach: Garden Grove Fwy. (22) East heading toward Orange. Take Main St. exit and turn right on Town and Country and right on Main St. heading north. Turn right on LaVeta. Turn left on Pepper.

From Newport Beach, Costa Mesa: Newport Fwy. (55) North to the Garden Grove Fwy. (22) West. Take Main St. exit in Orange, turn left heading west on La Veta Ave. Turn right on Pepper.

From Buena Park, Fullerton: Riverside Fwy. (91) East, to Orange Fwy. (57) South heading roward Orange. Take the Garden Grove Fwy. (22) East. Take Main St. Exit and turn right on Town and County and right on Main St. heading north. Turn right on LaVeta. Turn left on Pepper.

From Anaheim Hills, Yorba Linda, Placentia, Corona/Riverside areas: Newport Fwy. (55) South to Garden Grove Fwy. (22) West heading toward Long Beach. Take Main St. exit in Orange, turn left heading west on La Veta Ave. Turn right on Pepper.



1. CHOC Children's Hospital
2. CHOC Clinic and Research Buildings
3. CHOC Hospital & Clinic/Visitor Parking
4. **CHOC Emergency Department**
5. Emergency Department Valet
6. St. Joseph Hospital
7. St. Joseph Hospital Expansion
8. Providence Building
9. St. Joseph Outpatient Pavilion
10. St. Joseph Outpatient Pavilion Parking
11. Centrum North Building/CHOC Children's Neurology Clinic
12. Centrum North Parking
13. CHOC Commerce Tower/CHOC Children's Urology Center
14. CHOC Commerce Tower Parking
15. CHOC Associate Parking Structure
16. SJH Center for Cancer Treatment and Prevention
17. SJH Cancer Center Parking
18. Ronald McDonald House
19. Batavia Woods Medical Offices

*** Map not to scale**