



Pavilion for Women

DEPARTMENT OF RADIOLOGY ADULT

Central Scheduling Phone: 832-TC4-XRAY [832-824-9729] Fax: 832-825-5306

- ROUTINE, ASAP [PERFORMED WITHIN 2-4 HOURS], STAT [LIFE OR LIMB THREATENING; PERFORM IMMEDIATELY]

DO YOU WISH TO RECEIVE A PHONE CALL REPORT IMMEDIATELY AFTER STUDY IS READ BY RADIOLOGIST? PLEASE PROVIDE PHONE # TO CALL:

PHYSICIAN ORDER FORM

Patient's Name: Last, First, M.I.

D.O.B.: mm/dd/yyyy, Home Phone, Cell Phone

Address: Street Address, City, State, Zip

Guarantor Email

Insurance/Medicaid Plan, Policy & Group #

Authorization #, Please also fax copy of insurance card front & back with this order

Reason for Exam: (Signs, Symptoms, Chief Complaint)

Ordering Physician's Signature, Office Contact, Practice Phone, Backline Phone, Fax

Physician Name, Date/Time Signed, PCP Name (if different), SPECIAL INSTRUCTIONS: Schedule for Date/Time, Send CD with patient

ULTRASOUND: PELVIC, ABDOMEN, VASCULAR, SMALL PARTS, SOFT TISSUE

X-RAY: Skull, Sinuses, Neck, C-Spine, T-Spine, L-Spine, Abdomen, etc.

- ROUTINE  
 ASAP [PERFORMED WITHIN 2-4 HOURS]  
 **STAT [LIFE OR LIMB THREATENING; PERFORM IMMEDIATELY]**

DO YOU WISH TO RECEIVE A PHONE CALL REPORT IMMEDIATELY AFTER STUDY IS READ BY RADIOLOGIST?  
 PLEASE PROVIDE PHONE # TO CALL: \_\_\_\_\_

**PHYSICIAN ORDER FORM**

<b>CT</b>	<input type="checkbox"/> Without Contrast	<input type="checkbox"/> With Contrast	<input type="checkbox"/> Other-Specify _____
<input type="checkbox"/> Head/Brain	<input type="checkbox"/> Abdomen/Pelvis (with contrast)	<input type="checkbox"/> Hand	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Orbit	<input type="checkbox"/> Abd/Pelvis (w/o contrast) [Renal Stone]	<input type="checkbox"/> Finger(s) Specify _____	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Temporal Bones	<input type="checkbox"/> Urogram (with and without contrast)	<input type="checkbox"/> Hip(s)	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Maxillofacial	<input type="checkbox"/> Chest	<input type="checkbox"/> Femur	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Neck Soft Tissue	<input type="checkbox"/> Chest/Abdomen/Pelvis	<input type="checkbox"/> Knee	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Paranasal Sinus	<input type="checkbox"/> Shoulder <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Tibia/Fibula	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Paranasal Sinus Fusion	<input type="checkbox"/> Humerus <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Ankle	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> Elbow <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Foot	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/> Forearm <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Toe(s) Specify _____	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/> Wrist <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> 3D Rendering	

**CT ANGIOGRAPHY**

Head  
 Neck  
 Chest Pulmonary Embolism (with contrast)  
 Chest/Abdomen/Pelvis (with contrast)  
 Upper Extremity \_\_\_\_\_  L  R  
 Lower Extremity \_\_\_\_\_  L  R

<b>MRI</b>	<input type="checkbox"/> Without Contrast	<input type="checkbox"/> With AND Without Contrast	
<b>Neurologic</b>	<b>Musculoskeletal</b>		<b>Body</b>
<input type="checkbox"/> Brain	<input type="checkbox"/> Shoulder <input type="checkbox"/> L <input type="checkbox"/> R		<input type="checkbox"/> Abdomen _____ (Specify)
<input type="checkbox"/> Brachial Plexus	<input type="checkbox"/> Humerus <input type="checkbox"/> L <input type="checkbox"/> R		<input type="checkbox"/> Chest
<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> Elbow <input type="checkbox"/> L <input type="checkbox"/> R		<input type="checkbox"/> Cardiac
<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/> Forearm <input type="checkbox"/> L <input type="checkbox"/> R		<input type="checkbox"/> Fetal
<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/> Wrist <input type="checkbox"/> L <input type="checkbox"/> R		<input type="checkbox"/> Pelvis (Gyn)
<input type="checkbox"/> Face	<input type="checkbox"/> Hand <input type="checkbox"/> L <input type="checkbox"/> R		
<input type="checkbox"/> IACs	<input type="checkbox"/> Finger(s) Specify _____ <input type="checkbox"/> L <input type="checkbox"/> R		
<input type="checkbox"/> Orbits	<input type="checkbox"/> Hips and Pelvis <input type="checkbox"/> L <input type="checkbox"/> R		
<input type="checkbox"/> Pituitary	<input type="checkbox"/> Hip <input type="checkbox"/> L <input type="checkbox"/> R		
<input type="checkbox"/> Neck	<input type="checkbox"/> Femur <input type="checkbox"/> L <input type="checkbox"/> R		
<input type="checkbox"/> Temporal mandibular Joints	<input type="checkbox"/> Knee <input type="checkbox"/> L <input type="checkbox"/> R		
	<input type="checkbox"/> Tibia/Fibula <input type="checkbox"/> L <input type="checkbox"/> R		
	<input type="checkbox"/> Ankle <input type="checkbox"/> L <input type="checkbox"/> R		
	<input type="checkbox"/> Foot <input type="checkbox"/> L <input type="checkbox"/> R		
	<input type="checkbox"/> Toe(s) Specify _____ <input type="checkbox"/> L <input type="checkbox"/> R		

**MRA**  Brain  Neck  Chest  Abdomen  Pelvis  Extremity [Upper/Lower] \_\_\_\_\_  L  R  
**MRV**  Brain  Neck  Chest  Abdomen  Pelvis  Extremity [Upper/Lower] \_\_\_\_\_  L  R

<b>FLUOROSCOPY</b>	<b>MUSCULOKELETAL</b>
<input type="checkbox"/> Hysterosalpingogram (HSG)	<input type="checkbox"/> Arthrocentesis: <b>MRI (Arthrogram)</b> <input type="checkbox"/> L <input type="checkbox"/> R <b>Shoulder/Elbow/Wrist/Finger/Hip/Knee/Ankle/Toe + Injection</b>
<input type="checkbox"/> Esophagram	<input type="checkbox"/> Steroid Injection <input type="checkbox"/> L <input type="checkbox"/> R <b>Shoulder/Elbow/Wrist/Finger/Hip/Knee/Ankle/Toe</b>
<input type="checkbox"/> SBFT (Small Bowel)	<input type="checkbox"/> Tendon Sheath Injection <input type="checkbox"/> L <input type="checkbox"/> R <b>Shoulder/Elbow/Wrist/Finger/Hip/Knee/Ankle/Toe</b>
<input type="checkbox"/> Upper GI	<input type="checkbox"/> Ganglion Cyst Aspiration <input type="checkbox"/> L <input type="checkbox"/> R <b>Shoulder/Elbow/Wrist/Finger/Hip/Knee/Ankle/Toe</b>
<input type="checkbox"/> Contrast Enema	
<input type="checkbox"/> Voiding Cystourethrogram [VCUG]	

**INTERVENTIONAL RADIOLOGY**

<input type="checkbox"/> Fine Needle Aspiration	<input type="checkbox"/> PICC <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Lumbar Puncture	<input type="checkbox"/> Drain Placement, Nephrostomy
<input type="checkbox"/> Thoracentesis	<input type="checkbox"/> Placement	<input type="checkbox"/> Interventional Consult	<input type="checkbox"/> Biopsy
<input type="checkbox"/> Paracentesis	<input type="checkbox"/> Exchange	<input type="checkbox"/> Port Placement/Removal	<input type="checkbox"/> Pleura
	<input type="checkbox"/> Removal	<input type="checkbox"/> Central Line Placement [Apheresis]	<input type="checkbox"/> Liver Percutaneous
	<input type="checkbox"/> Reposition	<input type="checkbox"/> Nephrogram	<input type="checkbox"/> Thyroid
	<input type="checkbox"/> Tunnel	<input type="checkbox"/> Catheter Exchange, Nephrostomy	<input type="checkbox"/> Other _____

**Texas Children's Pavilion for Women (in the Texas Medical Center)**  
 6651 Main Street, 4<sup>th</sup> floor  
 Houston, TX 77030  
 women.texaschildrens.org

**Parking Options:**

- Park in Garage 21 (located underneath the Pavilion for Women)
- Take the elevators to the 4<sup>th</sup> floor
- Go straight past a set of elevators and make a left
- Walk past the wall of windows and you will see Women's Radiology on the right

**Directions from the Lobby/Valet:**

- Take the first set of elevators to the 4<sup>th</sup> floor
- Exit the elevator and walk down the hall of windows
- Women's Radiology will be on the right hand side near escalators

**Directions from West Tower:**

- Take elevator to third floor
- Use the bridge connection West Tower to the Pavilion for Women
- Take the escalator up to the 4<sup>th</sup> floor (escalators will be before you get to the Starbucks)
- Women's Radiology will be directly in front of the escalators

