MEDICAL RECORD	Orders Manual: Outpatient Clinic 3 (NCI)

Date: _____

Requestor:_____ **Patient's Diagnosis**:_____

Patient's Return Appointment:

Date/Time:	**Outpatient Clinic 3 Resources**			
	Adjuvant	Urology	Perfusion	Endocrine
	Immunotherapy	Thoracic	Surgery Consult	Other
	Phlebotomy			

If ordering a radiology test, ALL of the following must be included:

CT Scan Contraindications:
Patient on (circle one):
IL2: No
IL2: Yes, do not give contrast
IL2: Yes, may give contrast
Glucophage use: ☐Yes ☐No

Patient Transport Method:
Ambulatory
Wheelchair
Stretcher

MRI Contraindications:
Pacemaker (cardiac or neuro) or Auto Defibrillator: ☐Yes ☐No
Cochlear Implants: ☐Yes ☐No
Foreign Body in Eye: ☐Yes ☐No
Surgical Clips/Aneurysm: ☐Yes ☐No

Pregnancy
Yes
No
Unknown

CT Scan

Date/Time:	☐Chest	☐Chest, Abdomen, & Pelvis	☐IAC's
	☐Abdomen	☐Brain/Head	☐Other:
	☐Pelvis	☐Mediastinum	
	Indications:		

MRI

Date/Time:	☐Abdomen	☐Spine: Cervical / Thoracic / Lumbar	☐Liver/Spleen
	☐Brain	☐Extremities	☐Other:
	☐Kidney: Left / Right / Both		
	Indications:		

ULTRASOUND

Date/Time:	☐Abdominal	☐Liver	☐Kidney: Left / Right / Both
	☐Bladder/Gall Bladder	☐Pelvis	☐Other:
	Indications:		

XRAY

Date/Time:	☐Chest PA & Lat	☐Abdomen
	☐Skull	☐Extremities: Upper / Lower
	☐Spine: Cervical / Thoracic / Lumbar	☐Other:
	Indications:	

NUCLEAR MEDICINE

Date/Time:	☐Bone Scan	☐Gallium Scan
	☐Renogram/Mag 3	☐Other:
	Indications:	

MISCELLANEOUS

	Pulmonary Function Tests	EKG
	Indications:	*Indications:*

LIP Signature	LIP Name (printed)	Date