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 ☐ Specify, within: _____ days _____ weeks _____ months

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

Dx (All indications): _____

CT

Exam	Specify
☐ Head	
☐ Head- CT Angio	
☐ Orbits	
☐ Facial Bones, TMJ	
☐ Sinuses	
☐ Temporal Bones, IAC -Mastoid	
☐ Soft Tissue Neck	
☐ Cranio Cervical Jct	
☐ Cervical	
☐ Thoracic	
☐ Lumbar	
☐ Chest	
☐ Abdomen & Pelvis	☐ Kidney stone
☐ Abdomen Only	
☐ Pelvis Only	
☐ Shoulder	☐ Left ☐ Right ☐ Bilat
☐ Humerus	☐ Left ☐ Right ☐ Bilat
☐ Elbow	☐ Left ☐ Right ☐ Bilat
☐ Forearm	☐ Left ☐ Right ☐ Bilat
☐ Wrist	☐ Left ☐ Right ☐ Bilat
☐ Hand	☐ Left ☐ Right ☐ Bilat
☐ Hip	☐ Left ☐ Right ☐ Bilat
☐ Femur	☐ Left ☐ Right ☐ Bilat
☐ Knee	☐ Left ☐ Right ☐ Bilat
☐ Tib Fib	☐ Left ☐ Right ☐ Bilat
☐ Ankle	☐ Left ☐ Right ☐ Bilat
☐ Foot	☐ Left ☐ Right ☐ Bilat
☐ 3D Reconstruction	
☐ CT Angio (indicate body part):	

SCHEDULED FOR:

Date / Time: _____ Arrival Time: _____

Preparation: _____

Pre-Notification #: _____

IV CONTRAST:	**YES**	**NO**
IV Contrast	☐	☐
Previous contrast reaction (If yes, order prep)	☐	☐
Asthma (if yes, patient to bring inhaler)	☐	☐
Diabetes	☐	☐
Kidney Disease or Dialysis	☐	☐
Liver Disease	☐	☐
Sickle Cell Disease	☐	☐
Adrenal Tumor / Pheochromocytoma	☐	☐
INSTRUCTIONS:		
Allergies: _____	☐	☐
MRSA	☐	☐
Ventilator dependent	☐	☐
Pregnant	☐	☐
Child Life Services	☐	☐
Interpreter needed:	☐	☐
Language: _____		
Previous Images (Non-Gillette):	☐	☐
Location: _____ Date: _____		

Fax outside Reports to Gillette Imaging: Fax: 651-229-3921

Mail CD or film copies to: Gillette Childrens Imaging Dept.
200 University Ave E
St. Paul, MN 55101

SEDATION: Requires H&P within 7 days ☐ ☐
Fax H&P to 651-726-2643

Other Orders / Instructions:

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

Phone Number: _____ **Address:** _____

0118-905
01/11

Outside Provider CT Order