



Schedule by Phone  
**703.280.9800**



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**WashingtonRadiology.com**

**BRING THIS FORM TO YOUR APPOINTMENT**

**PATIENT INFORMATION**

Patient Name	DOB	Order Date (Required)	Patient Phone Number
Referring Clinician	Referring Clinician Signature/Stamp (Required)		Phone Number for Stat Reading (Required)

**PHYSICIAN'S WRITTEN ORDER**

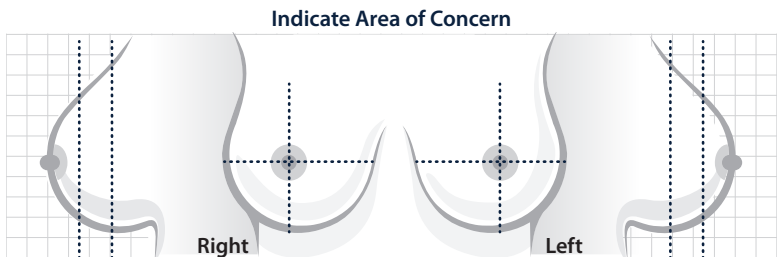
Clinical History, Symptoms, or Reason for Exam (Required) \_\_\_\_\_

**ULTRASOUND 2D/3D/4D**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Complete Abdomen                                      | <input type="checkbox"/> Pelvic Transabdominal only                             | <input type="checkbox"/> Venous Doppler Imaging of: _____     |
| <input type="checkbox"/> Limited Abdomen (eg: hernia, lump, gallstones): _____ | <input type="checkbox"/> Pelvic including Transvaginal and Doppler PRN          | <input type="checkbox"/> Testicular w/Doppler                 |
| <input type="checkbox"/> Liver Elastography                                    | <input type="checkbox"/> OB ____ weeks PRN TV, Doppler                          | <input type="checkbox"/> Sonohysterogram (SHG)                |
| <input type="checkbox"/> Musculoskeletal                                       | <input type="checkbox"/> BPP, Doppler ____ weeks                                | <input type="checkbox"/> Thyroid <input type="checkbox"/> FNA |
| <input type="checkbox"/> Interventional Studies                                | <input type="checkbox"/> OB/NT (11 weeks 1 day-13 weeks 6 days) PRN TV, Doppler | <input type="checkbox"/> Lymph Node Map of Neck               |
| <input type="radio"/> Joint Injection  | <input type="radio"/> With blood draw   | <input type="checkbox"/> Aorta (AAA)                          |
| <input type="radio"/> Nerve Injection  | <input type="radio"/> Without blood draw  | <input type="checkbox"/> Renal                                |
| <input type="radio"/> Aspiration   | <input type="checkbox"/> Carotid Doppler  | <input type="checkbox"/> Bladder                              |
|  | <input type="checkbox"/> Renal Arterial Doppler                                 | <input type="checkbox"/> Transrectal Prostate                 |

**BREAST STUDIES 2D/3D**

- |   |  |
|---|--|
| <input type="checkbox"/> Screening Mammogram with additional views and/or US, PRN | <input type="checkbox"/> Cyst Aspiration     |
| <input type="checkbox"/> Diagnostic Mammogram, US/Cyst Aspiration PRN             | <input type="checkbox"/> Ultrasound Biopsy   |
| <input type="checkbox"/> Screening Breast Ultrasound                              | <input type="checkbox"/> Stereotactic Biopsy |
| <input type="checkbox"/> Diagnostic Breast Ultrasound                             | <input type="checkbox"/> 3D Breast Biopsy    |
| <input type="radio"/> Mammogram PRN   | <input type="checkbox"/> MRI Biopsy          |
|   | <input type="checkbox"/> Breast MRI          |
|   | <input type="checkbox"/> FAST Breast MRI     |



**MRI**

**MRI CONTRAST:**  W  W/O  W & W/O  As Needed

- |                                      |  |   |   |                                       |
|--------------------------------------|--|---|---|---------------------------------------|
| <input type="checkbox"/> Brain       | <input type="checkbox"/> Soft Tissue Neck  | <input type="checkbox"/> Abdomen                | <input type="checkbox"/> MR Arthrography: _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Pituitary   | <input type="checkbox"/> Spine <input type="radio"/> C <input type="radio"/> T <input type="radio"/> L | <input type="checkbox"/> MRCP                   | _____   | _____                                 |
| <input type="checkbox"/> NeuroQuant™ | <input type="checkbox"/> Chest   | <input type="checkbox"/> Pelvis                 | <input type="checkbox"/> MR Angiography: _____  | _____                                 |
| <input type="checkbox"/> IAC         | <input type="checkbox"/> Breast <input type="radio"/> Biopsy <input type="radio"/> Implants            | <input type="checkbox"/> Joint/Extremity: _____ | _____   | _____                                 |
| <input type="checkbox"/> Orbits/Face |  |   |   |                                       |

**CT\***

**CT CONTRAST:**  W  W/O  W & W/O  As Needed

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Head                                     | <input type="checkbox"/> Chest             | <input type="checkbox"/> CT Urogram             | <input type="checkbox"/> Musculoskeletal: _____ |
| <input type="radio"/> Temporal Bone                               | <input type="checkbox"/> Lung Screening CT | <input type="checkbox"/> Renal (stone protocol) | <input type="radio"/> With 3D Rendering         |
| <input type="checkbox"/> Sinuses                                  | <input type="checkbox"/> Abdomen/Pelvis    | <input type="checkbox"/> Virtual Colonoscopy    | <input type="checkbox"/> Other: _____           |
| <input type="radio"/> Screening <input type="radio"/> Full Series | <input type="checkbox"/> CT Enterography   | <input type="checkbox"/> CT Angiography: _____  |   |
| <input type="checkbox"/> Neck                                     | <input type="checkbox"/> Abdomen           | <input type="radio"/> With 3D Rendering         |   |
| <input type="checkbox"/> Cardiac Calcium Scoring                  | <input type="checkbox"/> Pelvis            |   |   |
- \* Multiplanar Reconstruction performed as needed/requested.

**GENERAL X-RAY**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> PA Chest                        | <input type="checkbox"/> Hips                          | <input type="checkbox"/> Sinus  |
| <input type="checkbox"/> PA/Lat Chest                    | <input type="radio"/> Left <input type="radio"/> Right | <input type="checkbox"/> Spine  |
| <input type="checkbox"/> Flat/Erect Abdomen              | <input type="radio"/> Bilateral                        | <input type="radio"/> C <input type="radio"/> T <input type="radio"/> L |
| <input type="checkbox"/> Head                            | <input type="checkbox"/> KUB                           | <input type="checkbox"/> Extremity: _____                               |
| <input type="radio"/> Skull <input type="radio"/> Orbits | <input type="checkbox"/> Ribs                          | <input type="checkbox"/> Other: _____                                   |
| <input type="radio"/> Sinuses                            | <input type="checkbox"/> Scoliosis Survey              |   |

**FLUOROSCOPY**

- Esophagram
- Upper GI  Small Bowel
- Hysterosalpingogram (HSG)
- Other: \_\_\_\_\_

**BIOPSY (NON-BREAST)**

- Specify Site: \_\_\_\_\_

**BONE DENSITOMETRY**

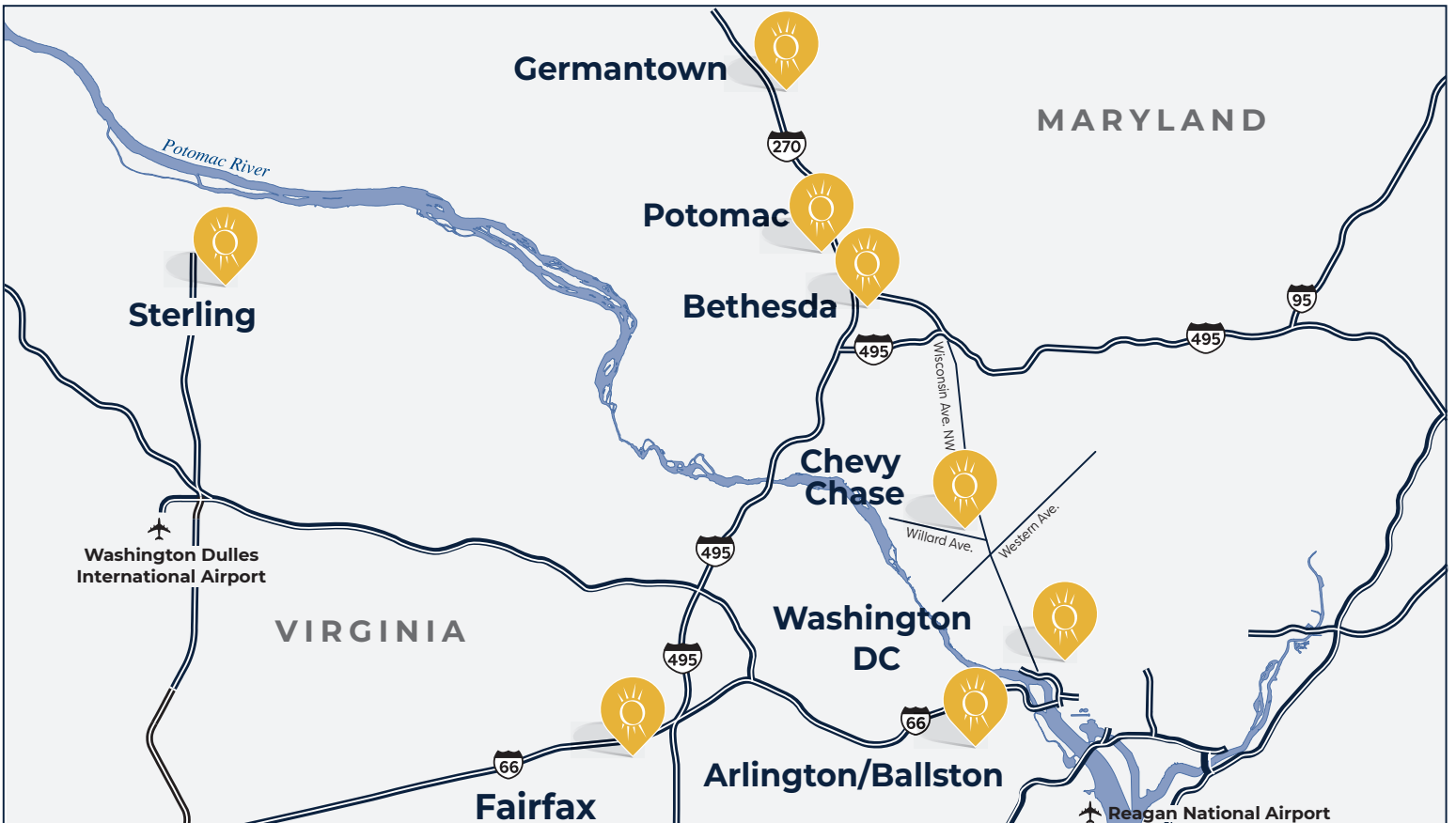
- DEXA Scan
- With VFA PRN

**Facility addresses and services on reverse side.**

# WASHINGTON RADIOLOGY

## LOCATIONS

	X-Ray	Bone Density	Fluoroscopy	2D & 3D Screening Mammo	2D & 3D Diagnostic Mammo	Ultrasound - Breast	Ultrasound - General	Ultrasound - Liver Elastography	CT	MRI	FAST Breast MRI	Biopsy - Breast	Biopsy - Thyroid
<b>Washington, DC</b> 2141 K Street NW, Suites 100, 111, 200, 900, Washington, DC 20037 P: 202.223.9722   F: 202.659.2819	•	•	•	•	•	•	•	•	•	•	•	•	•
<b>Chevy Chase, MD</b> 4445 Willard Avenue, Suite 200, Chevy Chase, MD 20815 P: 301.654.4242   F: 301.907.7414	•	•		•	•	•	•	•	•	•	•	•	•
<b>Bethesda, MD</b> 10215 Fernwood Road, Suite 103, Bethesda, MD 20817 P: 301.564.1053   F: 301.493.8522	•	•		•			•	•					•
<b>Potomac, MD</b> 12505 Park Potomac Avenue, Suite 120, Potomac, MD 20854 P: 240.223.4700   F: 240.223.4701		•		•	•	•				•	•	•	
<b>Arlington, VA</b> 1005 North Glebe Road, Suite 110, Arlington, VA 22201 P: 703.280.1410   F: 703.280.4751		•		•									
<b>Fairfax, VA</b> 3022 Williams Drive, Suites 104, 200, 204, Fairfax, VA 22031 P: 703.698.8800   F: 703.573.2318	•	•		•	•	•	•	•		•	•	•	•
<b>Sterling, VA</b> 21351 Ridgetop Circle, Suites 100, 150, Sterling, VA 20166 P: 571.434.0140   F: 571.434.0144	•	•		•	•	•	•	•	•			•	•
<b>Germantown, MD</b> 20410 Observation Dr., Suite 203, Germantown, MD 20876 P: 301.298.1426   F: 301.298.1428		•		•	•	•						•	



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