gillette CHILDREN'S

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): _____

Ultrasound

Exam	Specify
☐ Head	
☐ Neck	
☐ Abdomen	☐ Limited
☐ Pelvis	
☐ Hip	☐ In harness ☐ Out of harness
☐ Brachial Plexus	
☐ Joint: _____	
☐ Aorta	
☐ Carotid	
☐ Renal/Kidneys	
☐ Renal/Bladder	
☐ Thyroid	
☐ Testicular	
☐ Venous Arm	☐ Left ☐ Right
☐ Venous Leg	☐ Left ☐ Right
☐ Arterial Arm	☐ Left ☐ Right
☐ Arterial Renal	☐ Left ☐ Right
☐ Arterial Leg	☐ Left ☐ Right

Ultrasound Guidance

- ☐ Vascular access
- ☐ Needle placement
- ☐ Catheter placement
- ☐ Other:

Fluoroscopy

☐ Video Swallow with Speech	
☐ Esophagram	
☐ Upper GI	
☐ Small Bowel Follow Through	
☐ Colon	
☐ Colon Therapeutic	
☐ Cystogram	
☐ VCUG	
☐ Neck / Airway	
☐ Chest	
☐ Myelogram	☐ Cervical ☐ Thoracic ☐ Lumbosacral
☐ Arthrogram Joint _____	☐ Left ☐ Right

Fluoro Guidance

Exam	Specify (progress of tube)
☐ NG Tube Placement	
☐ NJ Tube Placement	
☐ GJ Tube Check	Tube Size: _____

Scheduled For:

Date / Time: _____

Arrival Time: _____

Preparation: _____

Instructions:	**YES**	**NO**
Allergies: _____	☐	☐
Ketogenic Diet	☐	☐
MRSA	☐	☐
Ventilator dependent	☐	☐
Pregnant	☐	☐
Child Life Services	☐	☐
Interpreter needed:	☐	☐
Language: _____		
Previous Images (Non-Gillette):	☐	☐

Location: _____ Date: _____

Fax 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

Other Orders/Instructions:

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

Phone Number: _____ **Address:** _____

Outside Provider Ultrasound / Fluoroscopy Order