



**JOHNS HOPKINS**  
M E D I C I N E

THE JOHNS HOPKINS HOSPITAL  
600 NORTH WOLFE STREET  
BALTIMORE, MD 21287

**Department of Radiology**  
**CT AND NEURO DIAGNOSTIC**

STAMP PATIENT'S IDENTIFICATION OR PRINT CLEARLY

Nursing Unit Clinic Birth Date

J.H.H. History Number

Patient's Name (LAST, FIRST, M.I.)

1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	<input type="checkbox"/> Routine <input type="checkbox"/> Urgent	Schedule Exam Date
<input type="checkbox"/> Allergic to Drugs	<input type="checkbox"/> On isolation	LMP <input type="checkbox"/> Pregnant
Ordering Provider (Print)	Attending Physician (Print)	
Ordering Provider (Signature)	Provider's ID Code	Phone or Beeper

*Insurance authorization number if applicable:*

**This exam may require contrast per protocol.**  
Please check this box if you DO NOT want your patient to receive contrast  No contrast  
*Reason for requesting non-contrast* \_\_\_\_\_

<p style="text-align: center;"><b>CHEST</b></p> <p><input type="checkbox"/> Chest Hi-res w/o IV Contrast <input type="checkbox"/> Chest Routine <input type="checkbox"/> Chest PE Prot w/IV Contrast <input type="checkbox"/> CTA Chest w/wo IV Contrast <input type="checkbox"/> CTA Cardiac w/wo IV Contrast <input type="checkbox"/> CTA Coronary Artery w/wo IV Contrast <input type="checkbox"/> Coronary Calcium Score w/o IV Contrast</p> <p style="text-align: center;"><b>CHEST AND ABDOMEN</b></p> <p><input type="checkbox"/> Chest ABD w/wo IV Contrast <input type="checkbox"/> CTA Chest ABD w/wo IV Contrast</p>	<p style="text-align: center;"><b>BODY CT EXAMINATIONS</b></p> <p style="text-align: center;"><b>ABDOMEN</b></p> <p><input type="checkbox"/> Abdomen complete routine <input type="checkbox"/> Abdomen complete Stone Survey <input type="checkbox"/> Adrenal Protocol <input type="checkbox"/> CTA ABD W IV Contrast <input type="checkbox"/> CTA ABD W IV Contrast Kidney <input type="checkbox"/> CTA ABD W IV Contrast Liver <input type="checkbox"/> CTA ABD W IV Contrast Pancreas <input type="checkbox"/> CT Bowel VIRT Colonoscopy <input type="checkbox"/> CT Small Bowel</p>	<p style="text-align: center;"><b>VASCULAR</b></p> <p><input type="checkbox"/> CT Aorta Chest W IV Contrast <input type="checkbox"/> CT Aorta ABD W IV Contrast <input type="checkbox"/> CT Aorta Chest/ABD W IV Contrast <input type="checkbox"/> Run Off Study W IV Contrast</p> <p style="text-align: center;"><b>MSK</b></p> <p><input type="checkbox"/> CT of Bone: Pelvis <input type="checkbox"/> CT of Bone: Upper Ext w/o IV Contrast <input type="checkbox"/> CT of Bone: Lwr Ext w/o IV Contrast <input type="checkbox"/> CTA Upper Ext w/wo IV Contrast <input type="checkbox"/> CTA LWR Ext w/wo IV contrast</p>
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<b>NEURO CT EXAMINATIONS</b>		
<p><input type="checkbox"/> CT Head <input type="checkbox"/> w/o <input type="checkbox"/> w <input type="checkbox"/> wo/w IV contrast <input type="checkbox"/> CT Temporal Bones <input type="checkbox"/> w/o <input type="checkbox"/> w IV contrast <input type="checkbox"/> CT Landmarx Sinus <input type="checkbox"/> CT Sinus <input type="checkbox"/> w/o <input type="checkbox"/> w IV contrast <input type="checkbox"/> CT Face <input type="checkbox"/> w/o <input type="checkbox"/> w IV contrast <input type="checkbox"/> CT Orbits <input type="checkbox"/> w/o <input type="checkbox"/> w IV contrast <input type="checkbox"/> CT Neck/Soft Tissue <input type="checkbox"/> w/o <input type="checkbox"/> w IV contrast</p>	<p><input type="checkbox"/> CTA Neck with IV Contrast <input type="checkbox"/> CTA Head with IV Contrast <input type="checkbox"/> CT Spine     <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> CT Myelo     <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> CT Other _____</p>	<p><input type="checkbox"/> CT Guided Tarlov Cyst Aspiration <input type="checkbox"/> CT guided Cryoablation of _____ <input type="checkbox"/> CT Guided Nerve Block Level _____ <input type="checkbox"/> CT Guided Denervation Level _____ <input type="checkbox"/> CT Guided Biopsy/Aspiration of _____ <input type="checkbox"/> CT Guided RFA of _____</p>

**Reconstructions**       2D       3D       Other \_\_\_\_\_

<b>NEURO DIAGNOSTIC EXAMINATIONS</b>	
<p><input type="checkbox"/> Spinal Puncture (<input type="checkbox"/> Cervical or <input type="checkbox"/> Lumbar) <input type="checkbox"/> Myelogram (<input type="checkbox"/> Cervical, <input type="checkbox"/> Thoracic or <input type="checkbox"/> Lumbar) <input type="checkbox"/> Nerve Block Level _____</p>	<p><input type="checkbox"/> Denervation Level _____ <input type="checkbox"/> Shunt Placement <input type="checkbox"/> Chemo Infusion</p>

<b>OTHER EXAMINATIONS REQUESTED</b>	<b>CLINICAL DX/RELEVANT CLINICAL FINDINGS</b>
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ACCESSION NUMBERS	ICD-9 or CPT CODES	EXAM CODES	DEPT CODE	SCHEDULED
				ARRIVED
	PROCEDURE ROOM	TIME IN	TIME OUT	TECHNOLOGIST