



JOHNS HOPKINS
M E D I C I N E

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

Department of Radiology
BREAST IMAGING AND ULTRASOUND

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	<input type="checkbox"/> Routine <input type="checkbox"/> Urgent	Scheduled Exam Date	
2 <input type="checkbox"/> Female			
<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:	

MAMMOGRAPHY EXAMS

- | | | |
|---|---|--|
| <input type="checkbox"/> Screening Mammogram | <input type="checkbox"/> Right Diagnostic Mammogram | <input type="checkbox"/> Right Breast Ultrasound |
| <input type="checkbox"/> Bilateral Diagnostic Mammogram | <input type="checkbox"/> Left Diagnostic Mammogram | <input type="checkbox"/> Left Breast Ultrasound |
| | | <input type="checkbox"/> Bilateral Breast Ultrasound |

ULTRASOUND EXAMINATIONS

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Abdomen
<input type="checkbox"/> RUQ (includes GB, Liver, Pancreas)
<input type="checkbox"/> Renal
<input type="checkbox"/> Aorta
<input type="checkbox"/> Ascites Mark
<input type="checkbox"/> Thoracentesis Mark
<input type="checkbox"/> Female Pelvis
<input type="checkbox"/> Obstetrical
<input type="checkbox"/> Male Pelvis
<input type="checkbox"/> Thyroid
<input type="checkbox"/> Neck
<input type="checkbox"/> Other: | <input type="checkbox"/> Carotid
<input type="checkbox"/> Liver Duplex
<input type="checkbox"/> Renal Doppler
<input type="checkbox"/> Renal Transplant
<input type="checkbox"/> Liver Transplant
<input type="checkbox"/> Pancreas Transplant
<input type="checkbox"/> Dialysis Graft
<input type="checkbox"/> Groin | <input type="checkbox"/> Lower Extremity Venous
<input type="checkbox"/> Right
<input type="checkbox"/> Left
<input type="checkbox"/> Bilateral
<input type="checkbox"/> Upper Extremity Venous
<input type="checkbox"/> Right
<input type="checkbox"/> Left
<input type="checkbox"/> Bilateral

PEDIATRICS
<input type="checkbox"/> Head
<input type="checkbox"/> Bowel
<input type="checkbox"/> Spine
<input type="checkbox"/> Hips | BIOPSIES/PROCEDURES
<input type="checkbox"/> Thyroid
<input type="checkbox"/> Neck Lymph Node
<input type="checkbox"/> Liver
<input type="checkbox"/> Liver Core
<input type="checkbox"/> Pancreas
<input type="checkbox"/> Renal Mass
<input type="checkbox"/> Retroperitoneal Mass
<input type="checkbox"/> Thoracentesis
<input type="checkbox"/> Ascites Tap
<input type="checkbox"/> Transplant
<input type="checkbox"/> Native Renal
<input type="checkbox"/> Other: |
|---|--|---|---|

OTHER EXAMINATIONS REQUESTED

CLINICAL DX/RELEVANT CLINICAL FINDINGS

ACCESSION CODES	ICD-9 or CPT CODES	EXAM CODES		DEPT CODE	SCHEDULED
					ARRIVED
	PROCEDURE ROOM	TIME IN	TIME OUT	TECHNOLOGIST	