



JOHNS HOPKINS
M E D I C I N E

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

Department of Radiology
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"/> ASAP <input type="checkbox"/> STAT	DATE		
<input type="checkbox"/> Allergic to Drugs	<input type="checkbox"/> On isolation	LMP	<input type="checkbox"/> Pregnant	Unable to Walk <input type="checkbox"/> Stand <input type="checkbox"/>
Attending Physician		Ordering Physician (Print)		
Ordering Physician Signature		Doctor Number	Phone or Beeper	<input type="checkbox"/> Radiologist to determine views/contrast

RADIOLOGY EXAMINATIONS (✓) CHECK EXAMINATIONS REQUESTED

Transported to Radiology Department By: Wheelchair Stretcher Requested As Portable Exam

<input type="checkbox"/> Chest, PA & Lat <input type="checkbox"/> Chest, PA <input type="checkbox"/> Chest, AP <input type="checkbox"/> Chest AP & Lat (Peds) <input type="checkbox"/> Babygram <input type="checkbox"/> Abdomen, KUB <input type="checkbox"/> Abdomen, supine & erect <input type="checkbox"/> Abdomen AP & L Lat Decubitus <input type="checkbox"/> Lateral Cervical Spine <input type="checkbox"/> Cervical Spine AP & Lateral <input type="checkbox"/> Cervical Spine & Obliques <input type="checkbox"/> Thoracic spine <input type="checkbox"/> Lumbar Spine	<input type="checkbox"/> Pelvis <input type="checkbox"/> Pelvis & Lateral R Hip <input type="checkbox"/> Pelvis & Lateral L Hip <input type="checkbox"/> Pelvis with Frog Legs (Peds) <input type="checkbox"/> Air Contrast Barium Enema <input type="checkbox"/> Barium Enema <input type="checkbox"/> Upper GI Series <input type="checkbox"/> Upper GI & Small Bowel <input type="checkbox"/> Small Bowel - only <input type="checkbox"/> Cine Esophagopharyngogram <input type="checkbox"/> Cine Esophagopharyngogram with Therapist (Peds & Adults)	<input type="checkbox"/> Scoliosis <input type="checkbox"/> Metastatic Bone Survey <input type="checkbox"/> Lateral Soft Tissue Neck <input type="checkbox"/> Bone Age <input type="checkbox"/> Trauma Survey <input type="checkbox"/> Upper Extremity (Peds) <input type="checkbox"/> Lower Extremity (Peds) <input type="checkbox"/> Sinus Tract Injection
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EXTREMITIES (LIMBS)

ANKLE	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral	FOOT	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral	TIBIA & FIBULA	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral	ELBOW	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral	HIP	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral
HAND	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral	WRIST	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral	FEMUR	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral	HAND & WRIST	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral	KNEE	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral

OTHER EXAMINATIONS REQUESTED	CLINICAL DX/RELEVANT CLINICAL FINDINGS
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ACCESSION NUMBERS	EXAM CODES	ICD-9 CODES	DEPT CODE	SCHEDULED
				ARRIVED

FLUORO TIME	FLUOROSCOPIST	X-RAY ROOM	TIME IN	TIME OUT	TECHNOLOGIST	PATIENT SHIELDED
			:	:		YES NO