



**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	

**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* \_\_\_\_\_

**RADIOLOGY EXAMINATIONS (✓) CHECK EXAMINATIONS REQUESTED**

<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)**

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

<b>OTHER EXAMINATIONS REQUESTED</b>	<b>CLINICAL DX/RELEVANT CLINICAL FINDINGS</b>
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ACCESSION NUMBERS	ICD9 or CPT CODES	EXAM CODES	DEPT CODE	SCHEDULED			
				ARRIVED			
FLUORO TIME	RADIOLOGIST	X-RAY ROOM	TIME IN	TIME OUT	TECH #	PATIENT SHIELDED	
			:	:		YES	NO