(place patient label here)

Patient Name:_____

BENEFIS HEALTH SYSTEM
Benefis
HOSPITALS

PROVIDER ORDERS

Order Set Directions:
- **(√)- Check orders to activate; Orders with pre-checked box ☑ will be followed unless lined out.**
- **Initial each place in the pre-printed order set where changes such as additions, deletions or line outs have been made**
- **Initial each page and Sign/Date/Time last page**

Diagnosis: _____

Allergies with reaction type:_____

Common Radiology and Diagnostic Tests

Version 1 2/5/14

Radiology and Diagnostic Tests

XR Chest Single, portable,
- ☐ routine Reason for exam: _____

XR Chest PA and Lateral
- ☐ routine Reason for exam: _____

XR Abdomen 1 View
- ☐ routine Reason for exam: _____

XR Abdomen Complete 2 View
- ☐ routine Reason for exam: _____

XR Abdomen Complete w/ PA Chest
- ☐ routine Reason for exam: _____

CT Head without Contrast
- ☐ routine Reason for exam: _____

CT PE Chest
- ☐ routine Reason for exam:_____

CT Abd/Pelvis with IV Contrast
- ☐ routine Reason for exam: _____

MRI Brain without Contrast
- ☐ routine Reason for exam: _____

MRI Brain wo+w Contrast
- ☐ routine Reason for exam: _____

US Carotid Doppler
- ☐ routine Reason for exam: _____

US Venous Doppler Lower Ext
- ☐ routine Reason for exam: _____

US Pelvic Complete
- ☐ routine Reason for exam: _____

US Abdomen Limited/ Follow-up
- ☐ routine Reason for exam: _____

☐ IR Miscellaneous Reason for exam: _____
Additional Instructions _____
Specific Procedure Requested _____

Cardiology

ECG
- ☐ routine Reason for exam: _____

ECHO, Transthoracic Complete
- ☐ stat ICD 9 Indications: _____Contrast? [ ] Yes [ ] No
  Agitated Saline (Bubble Study) [ ] Yes [ ] No Additional Instructions: _____
- ☐ routine ICD 9 Indications: _____Contrast? [ ] Yes [ ] No
  Agitated Saline (Bubble Study) [ ] Yes [ ] No Additional Instructions: _____

ECHO, Transthoracic Limited
- ☐ stat ICD 9 Indications: _____Area of Focus:
  _____Additional Instructions: _____
- ☐ routine ICD 9 Indications: _____Area of Focus:
  _____Additional Instructions: _____

Initials_____

(place patient label here)

Patient Name: _____

Order Set Directions:

- **(√)- Check orders to activate; Orders with pre-checked box ☑ will be followed unless lined out.**
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BENEFIS HEALTH SYSTEM
Benefis
HOSPITALS

PROVIDER ORDERS

ECHO, Transesophageal

☐ routine **Cardiology Consult required** Reason for exam:

_____Additional Instructions: _____

Holter Monitor

☐ [ ] 24 hour [ ] 48 hour Reason for exam: _____

Provider Signature:_____Date:_____Time:_____