LOMA LINDA UNIVERSITY
CHILDREN'S HOSPITAL

RADIOLOGY REQUEST FORM

CT

Computerized Tomography

Patient's Name (Last, First) _____ Date of Birth _____
Patient's Phone Number _____ Weight _____
List Any Allergies _____ Diabetic ○ Yes ○ No
Symptoms or Reason for Exam _____ ICD-10 Code(s) _____

PLEASE NOTE: Procedures will NOT be performed without a complete and signed order.

HEAD AND NECK
- Head (Select item)
- Orbits and Temporal Bone (Select item)
- Maxillofacial (Select item)
- Sinuses (Select item)
- Neck Soft Tissue (Select item)

UPPER EXTREMITIES
- Shoulder (Select item)
- Humerus (Select item)
- Elbow (Select item)
- Forearm (Select item)
- Wrist (Select item)
- Hand (Select item)

SPINE
- C-Spine (Select item)
- T-Spine (Select item)
- L-Spine (Select item)

CHEST, ABDOMEN AND PELVIS
- Chest (Select item)
- Abdomen (Select item)
- Abdomen and Pelvis (Select item)
- Pelvis (Select item)

LOWER EXTREMITIES
- Hip (Select item)
- Femur (Select item)
- Knee (Select item)
- Tibia Fibula (Select item)
- Ankle (Select item)
- Foot (Select item)

SPECIAL/MISCELLANEOUS
- Angio (Select item)
- Miscellaneous (Select item)

Ordering Provider
(Print Name and Title) _____

Signature (Required) _____ Date _____
Phone Number _____ NPI# _____

Please FAX the completed form to 909-558-0141, then call to schedule appointment at 909-558-5533, option 2.

You can place orders and view results faster using llucarelink.org. Learn more at:
http://lluhconnection.org/loma-linda-university-health-carelink.

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