



**JOHNS CREEK
DIAGNOSTIC
C E N T E R**

6920 McGinnis Ferry Rd
Suite 300
Suwanee, GA 30024
(678) 835-2299
Fax (678) 835-2296
HOURS: M-F
8AM-6 PM

PHYSICIAN ORDER FORM

JCDC to Schedule Patient

Patient Name	Date of Birth
Appt. Date/Time	Patient Phone
Referring Physician	Date
Phone	Fax
Diagnosis	Nurse

Referring Physician Signature

<input type="checkbox"/> Routine	<input type="checkbox"/> Film
<input type="checkbox"/> Stat	<input type="checkbox"/> CD
<input type="checkbox"/> Call Report	

MRI

- (circle appropriate)
- | | | |
|---|---|---|
| <input type="radio"/> Without Contrast | <input type="radio"/> Without & With Contrast | <input type="checkbox"/> Arthrogram |
| <input type="radio"/> Chance of pregnancy | <input type="radio"/> As per Radiologist | <input type="checkbox"/> Shoulder (R / L) |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Cervical Spine | <input type="checkbox"/> Elbow (R / L) |
| <input type="checkbox"/> Pituitary | <input type="checkbox"/> Thoracic Spine | <input type="checkbox"/> Wrist (R / L) |
| <input type="checkbox"/> IAC's | <input type="checkbox"/> Lumbar Spine | <input type="checkbox"/> Hip (R / L) |
| <input type="checkbox"/> Orbits | <input type="checkbox"/> MRCP | <input type="checkbox"/> Knee (R / L) |
| | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Ankle (R / L) |
| | <input type="checkbox"/> Boney Pelvis | <input type="checkbox"/> Foot (R / L) |
| | <input type="checkbox"/> Female Pelvis | |
| | <input type="checkbox"/> Soft Tissue Neck | |
| | <input type="checkbox"/> Other | |
- MRA:** Brain Neck Renals

CT

- | | | |
|---|--|---|
| <input type="radio"/> Without Contrast | <input type="radio"/> Chance of Pregnancy | |
| <input type="radio"/> With Contrast | <input type="radio"/> Allergic to iodine | |
| <input type="radio"/> Without & With Contrast | | |
| <input type="radio"/> As per Radiologist | <input type="checkbox"/> Chest (Thorax) | <input type="checkbox"/> Lower Extremity (R / L) |
| <input type="checkbox"/> Brain/Head | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Lumbar Spine |
| <input type="checkbox"/> Facial Bones | <input type="checkbox"/> Pelvis | <input type="checkbox"/> Cervical Spine |
| <input type="checkbox"/> Temp Bones/IAC's/Orbits | <input type="checkbox"/> Kidney Stone Study | <input type="checkbox"/> 3D Recons |
| <input type="checkbox"/> Soft Tissue Neck | <input type="checkbox"/> CT Enterography | <input type="checkbox"/> CT Angiography - PE/Head/Renal |
| <input type="checkbox"/> Sinus Axial & Coronal | <input type="checkbox"/> Upper Extremity (R / L) | <input type="checkbox"/> Other |
| <input type="checkbox"/> Sinus Ltd / Coronal Only | | |

ULTRASOUND

- | | | |
|---|---|---|
| <input type="checkbox"/> Complete Abdomen | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Venous Doppler Upper Extremity
(R / L) / Bilateral (Circle One) |
| <input type="checkbox"/> Aorta | <input type="checkbox"/> Pelvic | |
| <input type="checkbox"/> Limited Abdomen
(Liver, Gallbladder, RUQ) | <input type="checkbox"/> OB (1st trimester) | <input type="checkbox"/> Venous Doppler Lower Extremity
(R / L) / Bilateral (Circle One) |
| <input type="checkbox"/> Renal (Kidney & Bladder) | <input type="checkbox"/> Scrotum / Testicular | |
| <input type="checkbox"/> Bladder (Pre & Post Void) | <input type="checkbox"/> Carotid | |
| | <input type="checkbox"/> Other | |

X-RAY

- | | | |
|---|------------------------------------|--|
| <input type="checkbox"/> MRI Screening | <input type="checkbox"/> Cervical | <input type="checkbox"/> Extremity <input type="checkbox"/> Left <input type="checkbox"/> Right |
| <input type="checkbox"/> Sinus | <input type="checkbox"/> Thoracic | <input type="checkbox"/> Shoulder <input type="checkbox"/> Humerous <input type="checkbox"/> Elbow |
| <input type="checkbox"/> Soft Tissue Neck | <input type="checkbox"/> Lumbar | <input type="checkbox"/> Forearm <input type="checkbox"/> Wrist <input type="checkbox"/> Hand |
| <input type="checkbox"/> Chest (PA & Lateral) | <input type="checkbox"/> AP Pelvis | <input type="checkbox"/> Finger |
| <input type="checkbox"/> Ribs <input type="checkbox"/> Bilat <input type="checkbox"/> Left <input type="checkbox"/> Right | <input type="checkbox"/> Other | <input type="checkbox"/> Hip <input type="checkbox"/> Femur <input type="checkbox"/> Knee |
| <input type="checkbox"/> Abdomen Series | | <input type="checkbox"/> Tibia-Fibula <input type="checkbox"/> Ankle <input type="checkbox"/> Foot |
| <input type="checkbox"/> KUB | | |