Billings Clinic
Bozeman

Billings Clinic Bozeman – Radiology Department

3905 Wellness Way Bozeman, MT 59718
Phone: 406-898-1700 Fax: 406-898-1709

Patient Name: _____ ☐ Male ☐ Female
DOB: ____ / ____ / ____ Patient Phone #: _____

General Radiology	
Exam Requested:	
	☐Right ☐Left ☐Bilateral
Clinical Indications:	
ICD-10:	
Ultrasound	
Exam Requested:	
	☐Right ☐Left ☐Bilateral For Vascular Studies: ☐Arm ☐Leg For Extremities: ☐Arterial ☐Venous
Clinical Indications:	
ICD-10:	
CT	
Exam Requested:	
	☐without contrast ☐with contrast ☐with & without contrast
	☐Patient has known or suspected renal disease ☐Patient has a **contrast allergy** ☐Patient has labs (CMP or Creatinine) ☐Patient has negative pregnancy test
Clinical Indications:	
ICD-10:	
MRI	
Exam Requested:	
	☐without contrast ☐with contrast ☐with & without contrast
	Is the patient claustrophobic? ☐No ☐Yes, but can tolerate exam ☐Yes, medication prescribed **Can the patient lie on their back for 30 min?** ☐Yes ☐No, oral medical prescribed **Does the patient have any of the following?** Pacemaker or defibrillator? ☐Yes ☐No Neurostimulators? ☐Yes ☐No Aneurysm clip? ☐Yes ☐No Cochlear implant? ☐Yes ☐No Previous surgery to area? ☐Yes ☐No Previous metal work? ☐Yes ☐No
Clinical Indications:	
ICD-10:	
Fluoroscopy	
Exam Requested:	
Clinical Indications:	
ICD-10:	

Physician Name: _____ **Phone**: _____ **Fax**: _____

Physician's Signature: _____ **Date**: ____ / ____ / ____