CLERMONT RADIOLOGY
MYRTLE BEACH

811 82nd Parkway, Ste. D
Myrtle Beach, SC 29572

Phone: (843) 692-0040
Fax: (843) 692-0046
www.ClermontRadiology.com

Patient Name: _____

Patient Phone: _____ DOB: _____

Diagnosis: _____

☐ Report only ☐ CD ☐ Portal

Open MRI Closed MRI *(Circle machine)*

☐ Cervical	☐ Shoulder	☐ L	☐ R
☐ Thoracic	☐ Elbow	☐ L	☐ R
☐ Lumbar	☐ Wrist	☐ L	☐ R
☐ Creatinine Test	☐ Hand	☐ L	☐ R
☐ Brain	☐ Hip	☐ L	☐ R
☐ Brain/Pituitary	☐ Knee	☐ L	☐ R
☐ Brain/IAC's	☐ Ankle	☐ L	☐ R
☐ Brain/Orbits	☐ Foot	☐ L	☐ R

☐ Other _____

X-Ray

☐ C-Spine		☐ Elbow	☐ L	☐ R
☐ T-Spine		☐ Forearm	☐ L	☐ R
☐ L-Spine		☐ Wrist	☐ L	☐ R
☐ Chest PA & LAT		☐ Hand	☐ L	☐ R
☐ Pelvis		☐ Ribs	☐ L	☐ R
☐ Bone Age Study		☐ Hip	☐ L	☐ R
☐ Abdomen/KUB		☐ Femur	☐ L	☐ R
☐ Skull		☐ Knee	☐ L	☐ R
☐ Sinus		☐ Tib/Fib	☐ L	☐ R
☐ Orbits		☐ Ankle	☐ L	☐ R
☐ Shoulder	☐ L DR ☐ R	☐ Foot	☐ L	☐ R
☐ Humerus	☐ L ☐ R	☐ Other _____		

Contrast

☐ Non-Contrast ☐ With Contrast
☐ Contrast at Radiologists' Discretion

Ultrasound

☐ Carotid Study (NICS)
☐ Abdominal
☐ ABI's
☐ RUQ; GB
☐ Arterial Study
☐ Upper ☐ Lower
☐ L ☐ R
☐ Breast _____
☐ Transvaginal ☐ Thyroid
☐ Bladder ☐ Testicle
☐ Renal ☐ Pelvic
☐ Venous Study (vein scan)
☐ Upper ☐ Lower ☐ L DR
☐ Other _____

Mammography

☐ Screening (Bilateral)
☐ Diagnostic
☐ Bilateral ☐ L ☐ R
☐ Include Ultrasound
☐ Bilateral ☐ L ☐ R

AUTHORIZATIONS (Please send clinical notes with the order.)

Authorization #: _____
Expiration Date: _____
Effective Term: _____

We are happy to obtain these for you!

Physician Name: _____ Physician Phone: _____

Physician Signature: _____ Date: _____

Report Fax Number: _____

Insurance Carrier: _____ Policy #: _____

Authorization #: _____ Referring Physician Fax #: _____

Please Fax Front and back of Patient's Insurance Card with Order.