Beach Cities ADVANCED IMAGING

To Schedule Appointments:
Tel: 310.265.3100
Fax: 310.265.3115

Locate us under Beverly Radiology Medical Group Tax ID #: 95-4651287

Appointment Date:_____ **Appointment Time:**_____ **Today's Date:**_____

Patient's Name:_____ **Date of Birth:**_____ **M** or **F** (circle one)

Patient's Phone:_____ **Alternate/ Cell Phone:**_____

Clinical History/Reason for Exam:_____

_____

_____

_____

Referring Physician:_____ **Physician Signature:**_____

Phone:_____ **Fax:**_____ ☐ **CD** ☐ **Films** ☐ **Patient to bring images to Doctor** ☐ **Wet Read**

Labs needed for Contrast Studies if any of the below are marked: Creatinine _____ Lab date (within 1 month): _____
☐ Diabetes ☐ Renal Disease

MRI

MRI
- ☐ **with Contrast**
- ☐ **without Contrast**
- ☐ **with/without Contrast**
- ☐ **Contrast as indicated**
- ☐ Brain
  - ☐ w/special attention to IAC
  - ☐ w/special attention to Pituitary
- ☐ Orbits
- ☐ TMJ
- ☐ Neck - Soft Tissue
- ☐ Spine:
  ___Cervical__Thoracic__Lumbar
- ☐ Extremity: Joint __Left __Right
  Specify body part_____
- ☐ Extremity: Non-Joint__Left __Right
  Specify Body Part_____
- ☐ Chest
- ☐ Abdomen
- ☐ Abdomen (MRCP)
- ☐ Pelvis
- ☐ Other:_____

MR Angiography (Incls Veins)
- ☐ **with Contrast**
- ☐ **without Contrast**
- ☐ **with/without Contrast**
- ☐ Brain
- ☐ Neck - Carotids
- ☐ Chest
- ☐ Abdomen
- ☐ Aorta __Renal
- ☐ Aorta and runoff vessels
- ☐ Pelvis
- ☐ Extremity: __Left __Right
- ☐ Other:_____

MR Arthrography __Left __Right
- ☐ Shoulder
- ☐ Elbow
- ☐ Wrist
- ☐ Hip
- ☐ Knee
- ☐ Ankle

CT

Diagnostic CT
- ☐ **with Contrast**
- ☐ **without Contrast**
- ☐ **with/without Contrast**
- ☐ **3D Rendering as indicated**
- ☐ **Contrast as indicated**
- ☐ Brain
- ☐ Orbits
- ☐ IAC Middle Ear
- ☐ Maxillofacial - Facial Bones
- ☐ Dental
- ☐ Dental (X2)
- ☐ Sinus (Maxillofacial)
- ☐ Neck (Soft Tissue)
- ☐ Spine:
  __Cervical __Thoracic __Lumbar
- ☐ Extremity __Left __Right
  Specify Body Part_____
- ☐ Chest
- ☐ Abdomen (Pelvis if Indicated)
- ☐ Abdomen and Pelvis
- ☐ Urogram (Abdomen/Pelvis)
- ☐ Pelvis
- ☐ Other:_____
  _____

CTA (angiography)
- ☐ Head
- ☐ Neck
- ☐ Extremity: __Upper __Lower
- ☐ Chest
- ☐ Abdomen
- ☐ Pelvis
- ☐ Calcium Score
- ☐ Other _____
  _____

Ultrasound

- ☐ Abdomen_____
- ☐ Abdomen Limited_____
  __Liver __Gallbladder
  __Upper Right Quadrant
- ☐ Abdomen w/Doppler if indicated
- ☐ Renal_____
  __w/Bladder
- ☐ Bladder_____
- ☐ Aorta/Retroperitoneal_____
- ☐ Pelvis (TV if indicated)
- ☐ Pelvis Transabdominal Only
- ☐ Scrotum ___w/Doppler
- ☐ Thyroid_____
- ☐ Venous Doppler (Duplex)_____
- ☐ Carotid Doppler (Duplex)_____
- ☐ Other_____
  _____

OB Ultrasound
- ☐ OB Ultrasound (TV if indicated)_
- ☐ Limited (Viability, Heart Beat, Position, Fluid, Placental Location)_____
- ☐ Follow-up -- specify documented problem_____
  Umbilical Artery Doppler
- ☐ Other _____
  _____

Womans Imaging

- ☐ **Screening Mammogram**
- ☐ **DEXA**

X-Ray

- ☐ Head:
  __Skull __Orbits __Sinuses
- ☐ Spine:
  __Cervical __Thoracic __Lumbar
- ☐ Chest: __PA ____PA/LAT
- ☐ Ribs:
  __Unilateral__Bilateral __w/PA Chest
- ☐ Abdomen: __KUB __Two Views
- ☐ Pelvis
- ☐ Hips w/AP pelvis, bilateral
  __Unilateral __L __R
- ☐ Extremity:
  __Left __Right __Bilateral
  Specify Body Part_____
- ☐ Other:_____
  _____

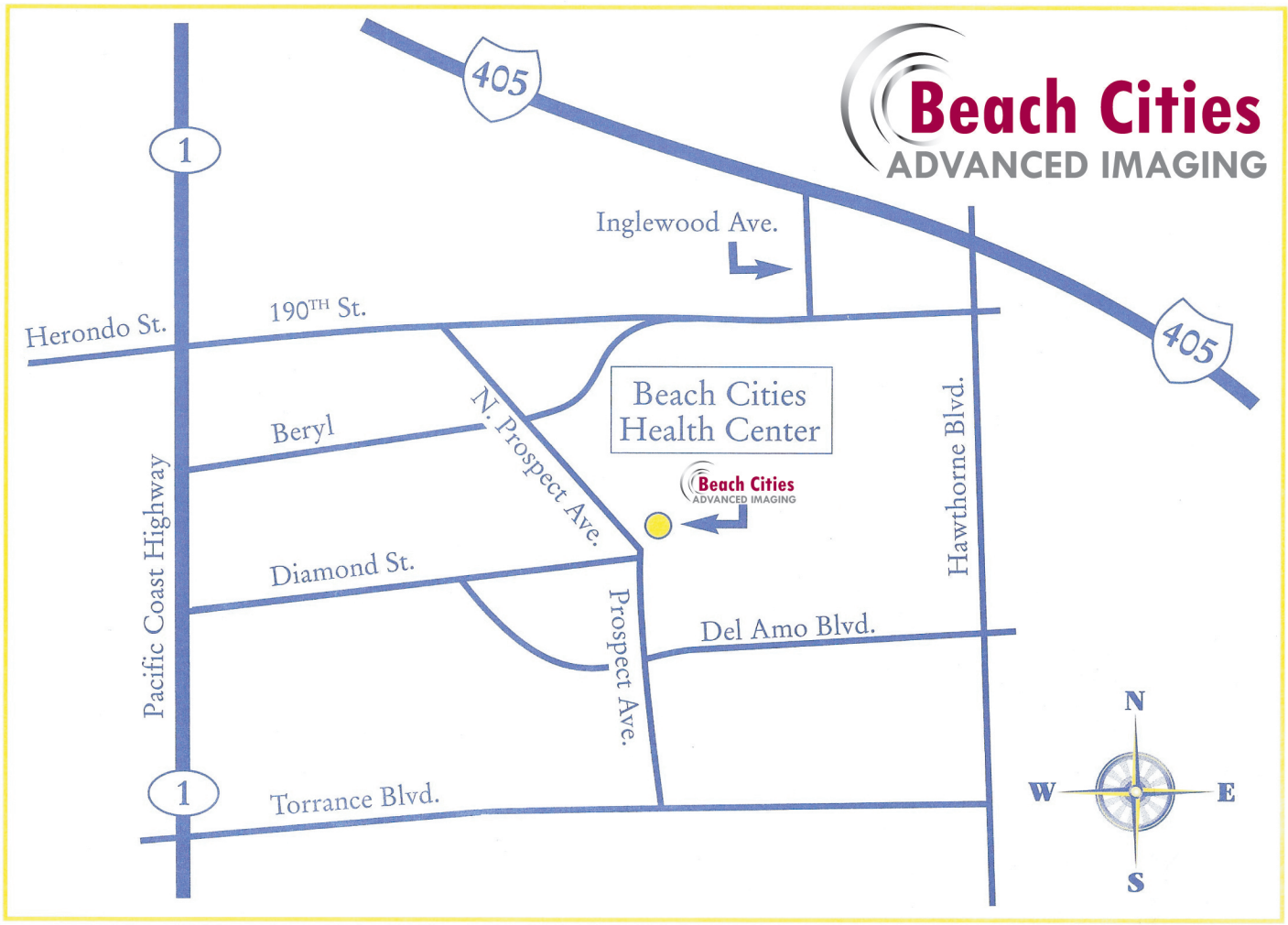
Scheduling Hours:

Monday - Friday:
8am - 5pm

For Directions and site information see back of this form*

www.RadNet.com

Thank you for choosing a RadNet Center.



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Office Hours:
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