

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

Patient's Name: _____ Date of Birth: _____

Clinical History/Reason for Exam: _____

Insurance Information: _____ Patient's Phone: _____

Referring Physician: _____ Physician Signature: _____

Phone: _____ Fax: _____ Patient to bring images to Doctor Call/Fax STAT results

Additional Report to: _____

MR

MRI

- With & Without Contrast
- With Contrast
- 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 _____
- Cardiac
- Chest
- Abdomen
 - ___MRCP
- Pelvis ___Bony Pelvis ___Soft Tissue
- Other: _____

MR Angiography: Specify Exam

- With & Without Contrast
- With Contrast
- Without Contrast
- Contrast, as Indicated
- 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 & Without Contrast
- With Contrast
- Without Contrast
- Contrast, as Indicated
- Creatinine: _____
- Lab Date: _____
- Brain
- Orbits
- IAC Middle Ear
- Maxillofacial - Facial Bones
- Sinus (Maxillofacial)
- Neck (soft tissue)
- Spine:
 - ___Cervical___Thoracic___Lumbar
- Extremity ___Left ___Right
 - Specify body part _____
- Chest
 - ___High Resolution Chest
- Abdomen (pelvis if indicated)
- Abdomen and Pelvis
- Urogram (abdomen/pelvis)
- Biopsy/Aspiration/Injection
- Pelvis
- Other: _____

CTA (angiography)

- Head
- Neck - Carotids
- Extremity: ___Upper ___Lower
- Chest
 - ___Thoracic Aorta ___Pulmonary
- Aorta and runoff vessels
- Abdomen
 - ___Renal Arteries
- Pelvis

Breast Imaging

- Screening Mammogram
- Diagnostic Mammogram
 - Breast Ultrasound (if indicated)
 - ___Unilateral ___Bilateral
- Breast Ultrasound
 - ___Left ___Right ___Bilateral
- Guided Needle Placement (Wire)
- Other: _____
- Date last mammogram: _____
- Breast implants: ___Yes ___No

Ultrasound

- Abdomen _____
- Abdomen Limited _____
 - ___Liver ___Gallbladder
 - ___Right Upper Quadrant
- Renal _____
 - ___w/Bladder
- Bladder _____
- Aorta/Retroperitoneal _____
- Pelvis (TV if indicated)
- Pelvis Transabdominal Only
- Hysterosonogram
- Scrotum ___w/Doppler
- Thyroid ___Soft Tissue Neck
- Biopsy/Aspiration/Injection
- Other _____

Vascular Studies

- Arterial Doppler (Duplex) _____
- Carotid Doppler (Duplex) _____
- Venous Doppler (Duplex) _____
- Other _____

OB Ultrasound

- OB Ultrasound (TV if indicated) _____
- Limited (Viability, Heart Beat, Position, Fluid, Placental Location) _____
- Follow-up -- specify documented problem _____
- Biophysical Profile _____
- Umbilical Artery Doppler _____

Fluoroscopy

- Arthrography
 - Specify body part _____
- IVP
- VCUG
- Esophagram
- Hysterosalpingogram (HSG)
- UGI
- UGI w/SBFT
- Small Bowel
- Barium Enema
- Other: _____

PET/CT

To Schedule a PET/CT Exam please use the PET/CT order form or call our office directly at: 209.475.9871

- PET/CT, Skull Base to Mid-Thigh
- PET/CT, Whole Body (Melanoma)
- PET/CT, Brain

X-Ray

- Head:
 - ___Skull ___Orbits ___Sinuses
- Spine:
 - ___Cervical ___Thoracic ___Lumbar
- Chest: ___PA ___PA/LAT
- Ribs:
 - ___Unilateral___Bilateral ___w/PA Chest
- Abdomen: ___KUB ___Two Views ___Abd Series
- Pelvis
- Hips w/AP Pelvis, Bilateral
 - ___Unilateral ___Left ___Right
- Extremity:
 - ___Left ___Right ___Bilateral
 - Specify Body Part _____
- Other: _____