Imaging Request

LANCASTER IMAGING
44725 10th Street West
Suites 140, 150 & 180
Lancaster, CA 93534
P: (661) 945-5855 • F: (661) 942-1519

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 in STAT results**

MR

MRI

- ☐ **3D Rendering**
- ☐ **With & Without Contrast**
- ☐ **With Contrast**
- ☐ **Without Contrast**
- ☐ Brain
  - ☐ w/special attention to IAC
  - ☐ w/special attention to Pituitary
- ☐ Breast
- ☐ Orbits
- ☐ TMJ
- ☐ Neck - Soft Tissue
- ☐ Spine:
  ___Cervical__Thoracic__Lumbar
- ☐ Extremity: Joint __Left __Right
  Specify body part____________
- ☐ Extremity:Non-joint __Left __Right
  Specify body part____________
- ☐ Abdomen
- ☐ MRCP
- ☐ Pelvis __Bony Pelvis __Soft Tissue
- ☐ Other:________________

MR Angiography

- ☐ **With & Without Contrast**
- ☐ **With Contrast**
- ☐ **Without Contrast**
- ☐ Brain
- ☐ Neck - Carotids
- ☐ Other:________________

MR Arthrography __Left __Right

- ☐ Shoulder
- ☐ Elbow
- ☐ Wrist
- ☐ Hip
- ☐ Knee
- ☐ Ankle

CT

Diagnostic CT

- ☐ **With & Without Contrast**
- ☐ **With Contrast**
- ☐ **Without Contrast**
- ☐ Brain
- ☐ Orbits
- ☐ IAC Middle Ear
- ☐ Facial Bones
- ☐ Sinus (Maxillofacial)
- ☐ Neck (soft tissue)
- ☐ Spine:
  __Cervical __Thoracic __Lumbar
- ☐ Myelogram
- ☐ Extremity__Left __Right
  Specify body part____________
- ☐ Chest
- ☐ Abdomen (pelvis if indicated)
- ☐ Abdomen and Pelvis
- ☐ Urogram (abdomen/pelvis)
  __Contrast if needed
- ☐ Pelvis
- ☐ Multi-Phase Liver
- ☐ Renal Mass
- ☐ Pancreatic Protocol
- ☐ Enterography
- ☐ Other:________________

CTA

- ☐ Head
- ☐ Neck
- ☐ Extremity:
  __Upper __Lower
- ☐ Chest
- ☐ Aorta & Runoff Vessel
- ☐ Abdomen
- ☐ Pelvic

Breast Imaging

- ☐ Screening Mammogram
- ☐ Diagnostic Mammogram
  Breast Ultrasound (if indicated)
- ☐ Breast Ultrasound
  __Left __Right
- ☐ Breast MRI

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
- ☐ Scrotum ___w/Doppler
- ☐ Thyroid____________
- ☐ Venous Doppler (Duplex)______
- ☐ Carotid Doppler (Duplex)______
- ☐ Arterial Doppler (Duplex)______
- ☐ Extremity (Non Vascular)
- ☐ Other________________

OB Ultrasound

- ☐ OB Ultrasound (TV if indicated)_
- ☐ Limited (Viability, Heart Beat, Position, Fluid, Placental Location)____________
- ☐ Follow-up -- specify documented problem____________
- ☐ Biophysical Profile____________

Fluoroscopy

- ☐ Arthrography
  Specify body part____________
- ☐ IVP
- ☐ VCUG
- ☐ Esophagram
- ☐ Hysterosalpingogram (HSG)
- ☐ UGI
- ☐ UGI w/SBFT
- ☐ Small bowel
- ☐ Barium enema
- ☐ Other:________________

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
- ☐ Extremity:
  __Left __Right __Bilateral

Specify Body Part____________
- ☐ Other:____________

Interventional

Paracentesis:
- ☐ Diagnostic
- ☐ Therapeutic

Thoracentesis: __Left __Right
- ☐ Diagnostic
- ☐ Therapeutic

Biopsy (Ultrasound Guided):
__Left __Right
- ☐ Breast
- ☐ Lymphnode
- ☐ Thyroid
- ☐ Soft Tissue Mass
- ☐ Liver
  - ☐ Targeted
  - ☐ Non-Targeted

Biopsy (CT Guided):
- ☐ Abdomen / Pelvis
  - ☐ Liver
  - ☐ Other
- ☐ Soft Tissue

Special IR Request:____________
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Indications:________________
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Please bring this form, I.D. and your insurance card with you on the day of your exam.

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