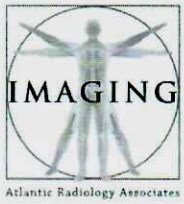

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Today's Date: ____/____/____ **Appt. Date/Time:** _____ ○ Male ○ Female

Last Name: _____ First Name: _____

DOB: / / Home Phone # : _____ Diagnostic code : _____

Reason for exam : _____

REFERRING PHYSICIAN _____

Phone: _____ Fax: _____

_____

Physician Signature

X-RAY

- ○ CXR
- ○ KUB
- ○ Abdomen Complete (KUB, Upright ABD, PA Chest)
- ○ Spine _____
- ○ Ortho _____
- ○ Other _____

ULTRA SOUND

- ○ Abdomen Complete
- ○ Abdomen Ltd (RUQ)
- ○ Abdominal Wall Limited (hernia)
- ○ Pelvis/Transabdominal
- ○ Pelvic/Transvaginal
- ○ Renal
- ○ Soft Tissue _____
- ○ Testicular/Scrotal
- ○ Thyroid
- ○ Tyroid FNA
- ○ AAA Screening

PEDIATRIC

- ○ Hips
- ○ Spine

VASCULAR

- ○ Aorta
- ○ Carotid
- ○ Venous Doppler (LE/UE) (Bil/Rt/Lt)
- ○ Arterial Doppler (LE/UE) (Bil/Rt/Lt)
- ○ Renal Artery Doppler

MAMMOGRAPHY

- ○ Screening Mammogram with Tomosynthesis
- ○ Diagnostic Bilateral Mammogram with Tomosynthesis
- ○ Diagnostic Unilateral Mammogram with Tomosynthesis R / L

CT

- ○ Brain
- ○ Sinuses
- ○ Facial Bones
- ○ Orbits
- ○ IAC
- ○ Soft Tissue Neck
- ○ Cervical
- ○ Thoracic
- ○ Lumbar
- ○ Chest
- ○ Abdomen
- ○ Pelvis
- ○ Abdomen/ Pelvis Renal Stone
- ○ CTA (specify) _____

- ○ Shoulder R / L
- ○ Elbow R / L
- ○ Wrist R / L
- ○ Pelvis R / L
- ○ Hip R / L
- ○ Knee R / L
- ○ Ankle R / L
- ○ Foot R / L

Contrast
- ○ With
- ○ Without
- ○ With & Without

MRI

- ○ Brain
- ○ Pituitary
- ○ IAC
- ○ Orbits
- ○ TMJ
- ○ Soft Tissue Neck
- ○ Cervical
- ○ Thoracic
- ○ Lumbar
- ○ Chest
- ○ Abdomen
- ○ Pelvis
- ○ MRA

(specify) _____

- ○ Hand R/L
- ○ Shoulder R / L
- ○ Elbow R / L
- ○ Wrist R / L
- ○ Hip R / L
- ○ Knee R / L
- ○ Ankle R / L
- ○ Forefoot R / L

Contrast
- ○ Without
- ○ With & Without

NOTES/OTHER EXAM:

PATIENTS RECEIVING ORAL SEDATION FOR CLAUSTROPHOBIA MUST BE ACCOMPANIED WITH A DRIVER.