

MAY REQUIRE SEDATION

STAT

Scheduling@Carefirstimaging.com

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APOPKA

840 E Semoran Blvd., Apopka, Florida 32703

WINTER PARK

1480 W Fairbanks Ave Suite 200, Winter Park, Florida 32789

PATIENT NAME: _____ DATE: _____

PHONE: _____ D.O.B: _____

DIAGNOSIS/ICD 10: _____ ATTORNEY: _____

INSURANCE: _____ CLAIM#/ID#: _____

Physician Notes / Other Procedures: _____

Based upon this patient's diagnosis, I have requested the below procedure(s). I hereby feel the tests are medically necessary.

PHYSICIAN: _____ PHYSICIAN SIGNATURE: _____

OFFICE PHONE: _____ OFFICE FAX: _____ AFTER HOURS: _____

IF CONTRASTED: BUN: _____ CREATININE: _____ EGFR: _____ DATE LABS WERE PERFORMED: _____

MRI 3T WINTER PARK ONLY

IV Contrast: _____ w/o _____ w/ + w/wo

Cervical (spine)
 Alar Protocol (whiplash injury protocol)
 Flex/ExT

Thoracic (spine)
 Lumbar (spine)

Brain Trauma SWI/DTI
 IACs/Brain Protocol

PITUITARY/Brain Protocol

Orbit

Face

Neck

Hip

L R

Knee

L R

Ankle

L R

Foot

L R

Shoulder

L R

Elbow

L R

Wrist

L R

Hand Finger

L R

Other: _____

MRA

IV Contrast: _____ w/o _____ w/ + w/wo

Circle of Willis/Head
 MRV Head / Brain High Field Only
 Other: _____

CT

IV Contrast: _____ w/o _____ w/ _____ w/wo (IV)

Oral: _____ Oral Contrast

Brain

Sinuses (Maxillofacial CT Image Guided Sinus)

Soft Tissue Neck

Chest

Low Dose (CT for lung cancer screening)

High Res

Heart Calcium Score

Abdomen (Only)

Abdomen and Pelvis

Renal Stone Protocol (No Oral or IV Contrast)

Pelvis (Only)

Facial Bones _____ w/o

Cervical _____ w/o

Thoracic _____ w/o

Lumbar _____ w/o

Extremity/Joint _____

Other: _____

CT IVP (No Oral)

ULTRASOUND

Pelvic w/ Transvaginal PRN

Fetal Limited <12wk gestation (single only)

Fetal Complete <12wk gestation (single only)

Carotid Doppler

Renal Doppler

Upper - Venous Atrial

Left Right

Lower - Venous Atrial

Left Right

Abdominal Aorta

Abdominal Complete

Abdominal Limited (RUQ)

(Liver Gallbladder, Pancreas, Rt, Kidney)

Renal Complete

(Kidneys, Bladder, Aorta)

Thyroid

Testicular w/ Doppler

Extremity soft tissue

Other (specify): _____

CTA ANGIOGRAPHY

AAA (w/ IV Contrast)

PE Protocol (w/ IV Contrast)

Thoracic AA (w/ IV Contrast)

Circle of Willis/Head (w/ IV Contrast)

Runoff (w/ IV Contrast)

Carotid (w/ IV Contrast)

CTA ABD / Pelvis

Coronary (w/ IV Contrast)

X-RAY

Chest (2 views)

Spine

Neck Cervical Thoracic Lumbar

C-Spine Flex/Ext L-Spine Flex/Ext

Flex/Ext

Davis Series

Other: _____

3D MAMMOGRAPHY

Digital Screening Mammography w/ CAD

Digital Screening Mammography w/ CAD
 Additional Views, Breast US. PRN

Bilateral Unilateral

MRI

1. Notify your Doctor if you have any of the following:
 - PACEMAKER/ICD
 - SURGERY IN THE PAST 6 WEEKS
 - HISTORY OF METAL WORK / WELDING
If Yes: may need Orbit XRAYS
 - CLAUSTROPHOBIA
2. Wear loose fitting clothes without zippers, buttons, or metal hooks.
3. Remove all piercings before coming to your appointment.
4. Your exam can take 30 min to 1 hr to complete **PER EXAM.**

ORAL SEDATION

1. Patient needs to have their own driver.
2. Patient must arrive 1 hour prior to appointment.

MAMMOGRAPHY

1. No Deodorant, lotions, or powders used on the chest and underarm area on the day of the exam.

CT

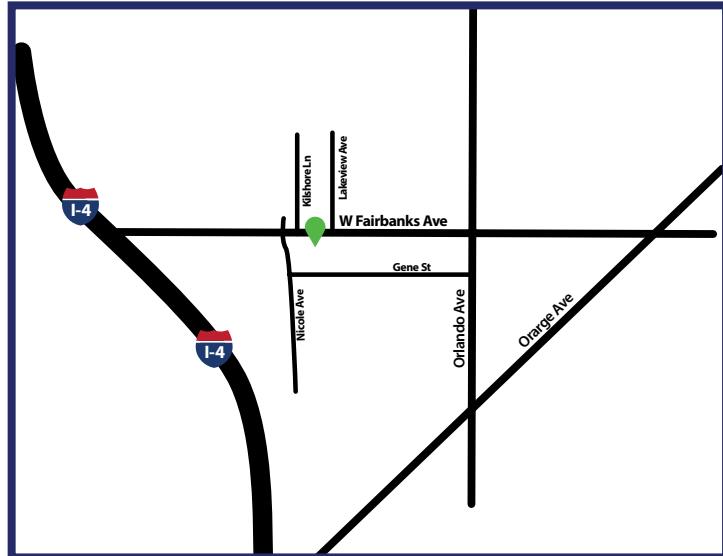
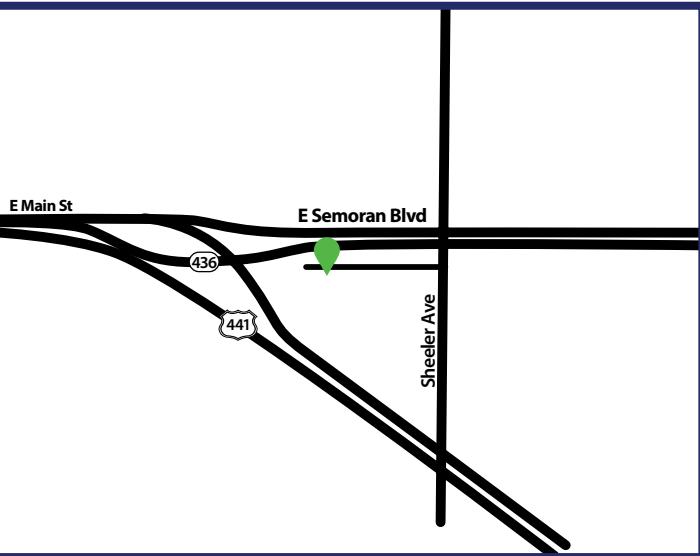
1. Recent blood work required for contrast exams.
2. Notify your Doctor if you have any allergies to IV Contrast prior to your exam if required.
3. Remember to pick up your oral contrast from our office.

CONTRAST

1. If over 60 years of age or diabetic.
2. Labs: BUN/ Creatinine and GFR.

ULTRASOUND

1. Begin drinking 32oz of water before the exam. Finish drinking ALL of the water before the appointment time. DO NOT VOID until after the exam.



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SCAN FOR
GPS DIRECTIONS
TO FACILITIES

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