CareFIRST IMAGING

1714 SW 17th St, Ocala, FL 34471
Toll Free Phone: 833-682-7818
Phone: 352-274-9565
Fax: 352-398-4061

CareFirst: NPI-1952763971
Tax ID#: 811981130

☐ MAY REQUIRE SEDATION ☐ STAT

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

IV Contrast: ___ w/o ___w/ + w/o

❑ Cervical (spine)
- ❑ Alar Protocol (whiplash injury protocol)

❑ Thoracic (spine)
❑ Lumbar (spine)
❑ Abdomen (Trauma / Injury only)
❑ Pelvis ❑ Bony ❑ Female
❑ TMJ
❑ Brain ❑ Trauma SWI/DTI
- ❑ 3D Volumetric Analysis

❑ Brain IACs
❑ Brain Pituitary
❑ Brain Orbits
❑ Face
❑ Neck - Soft Tissue

❑ 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/o

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

UPRIGHT/OPEN MRI

IV Contrast: ___ w/o ___w/ + w/o

❑ Brain
❑ Cervical (spine)
- ❑ Alar Protocol ❑ Flex/ExT

❑ T-Spine
❑ L-Spine ❑ Flex/ExT

XRAY

❑ Chest (2 views)
❑ Ribs ❑ L ❑ R ❑ Bilat
❑ Spine ❑ Cervical ❑ Thoracic ❑ Lumbar
- ❑ C-Spine Flex/Ext ❑ L-Spine /Ext
- ❑ C-Spine Oblique ❑ L-Spine Oblique
- ❑ Flex/Ext

❑ Davis Series

❑ Shoulder	❑ L	❑ R	
❑ Humerus	❑ L	❑ R	
❑ Elbow	❑ L	❑ R	
❑ Forearm			
❑ Wrist			
❑ Hand			
❑ Finger			
❑ Abdomen (2 view)			
❑ KUB (Abdomen)			
❑ Abdomen Series (3 View)			
❑ Hips	❑ L	❑ R	❑ Bilat
❑ Femur	❑ L	❑ R	
❑ Knee	❑ L	❑ R	❑ Bilat
❑ Tib/Fib	❑ L	❑ R	
❑ Ankle	❑ L	❑ R	
❑ Foot	❑ L	❑ R	
❑ Toes	❑ L	❑ R	

❑ Other(s)_____
❑ _____
❑ _____

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

❑ Abdomen (Only)
❑ 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)

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

ACR® American College of Radiology ACCREDITED FACILITY

CareFIRST IMAGING

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.

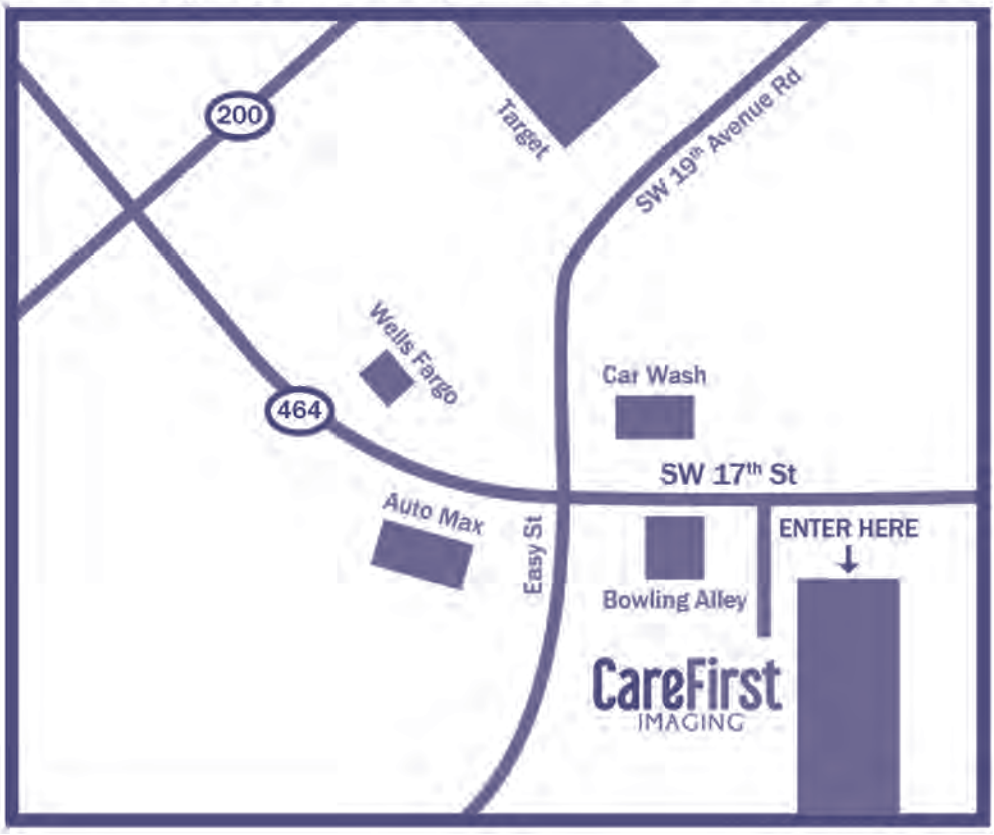
CT

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.

Next to Bowling Alley on 17th Street, inside the ONE HEALTH CENTER building.



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