

☐ **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 ■ 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
- ☐ Orbits
- ☐ 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: _____

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): _____

MRA

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

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

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: _____

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

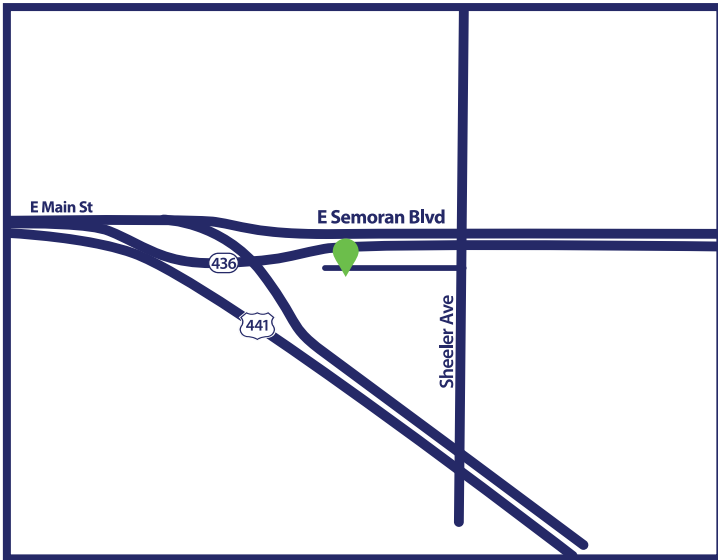
1. Recent blood work required for contrast exams.
2. Notify your Doctor if you have any allergies to IV Contrast prior to your exam if required.
3. Remember to pick up your oral contrast from our office.

CONTRAST

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

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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