



Leaders in Diagnostic Imaging...  
Champions in Patient Care.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Script: \_\_\_\_\_  
 Physician Name: \_\_\_\_\_ Physician Signature \_\_\_\_\_  
 CC Physician (s): \_\_\_\_\_  
 Clinical History: \_\_\_\_\_  
 Patient Insurance (Authorization Number, if applicable): \_\_\_\_\_

Request for Stat Results: Yes \_\_\_\_ No \_\_\_\_  
 Phone Number: \_\_\_\_\_  
 Fax Number: \_\_\_\_\_

Reason for Exam(s): ICD9 \_\_\_\_\_

<b>Diagnostic Procedures</b> <input type="checkbox"/> Abdomen (1 View) <input type="checkbox"/> Abdomen (2 View) <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Chest <input type="checkbox"/> Facial Bones <input type="checkbox"/> Joint Survey (RA) <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Mandible <input type="checkbox"/> Nasal <input type="checkbox"/> Pelvis <input type="checkbox"/> Pelvis w/hips <input type="checkbox"/> Scoliosis <input type="checkbox"/> Sinus <input type="checkbox"/> Sinus (1 view) <input type="checkbox"/> Skull <input type="checkbox"/> Thoracic Spine <b>Please Select:</b> <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Ankle <input type="checkbox"/> Elbow <input type="checkbox"/> Femur <input type="checkbox"/> Finger (s) _____ <input type="checkbox"/> Foot <input type="checkbox"/> Forearm <input type="checkbox"/> Hand <input type="checkbox"/> Hip <input type="checkbox"/> Humerus <input type="checkbox"/> Knee <input type="checkbox"/> Lower Leg <input type="checkbox"/> Ribs <input type="checkbox"/> Shoulder <input type="checkbox"/> Wrist  <b>Other:</b> _____	<b>Fluoroscopy</b> <input type="checkbox"/> BE w/ air <input type="checkbox"/> BE <input type="checkbox"/> GI <input type="checkbox"/> GI-Sm Bowel <input type="checkbox"/> Small Bowel <input type="checkbox"/> Esophagram <input type="checkbox"/> IVP <input type="checkbox"/> VCUGa  <input type="checkbox"/> Myelogram - Cervical / Thoracic / Lumbar / Complete	<b>For all Arthrograms</b>  <b>Please State: Body pt. &amp; Modality to follow</b>  <input type="checkbox"/> Xray only <input type="checkbox"/> CT <input type="checkbox"/> MR	<b>Bone Densitometry</b> <input type="checkbox"/> Hips / Spine _____ Other	<b>PET/CT</b> <input type="checkbox"/> Skull to Mid Thigh (Oncology) <input type="checkbox"/> Neurology <input type="checkbox"/> Skull to Mid Thigh (Pulmonary Nodule) <input type="checkbox"/> Cardiac <input type="checkbox"/> Whole Body (Melanoma only)	
	<b>Mammography</b> <input type="checkbox"/> Screening <input type="checkbox"/> Diagnostic <input type="checkbox"/> Bilateral Mammogram <input type="checkbox"/> Unilateral Mammogram <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Press Outs <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Magnification Views <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Ultrasound Breast, if needed  <b>Stereotactic Breast Biopsy</b> <input type="checkbox"/> Right <input type="checkbox"/> Left	<b>Ultrasound</b> <input type="checkbox"/> Abdomen <input type="checkbox"/> Abdomen Limited /RUQ <input type="checkbox"/> Abdominal Aorta <input type="checkbox"/> Adult Echo <input type="checkbox"/> Biophysical profile <input type="checkbox"/> Breast R L Bilat <input type="checkbox"/> Carotid doppler <input type="checkbox"/> Kidneys & Bladder <input type="checkbox"/> Obstetrical <input type="checkbox"/> Pediatric Hips <input type="checkbox"/> Pelvis <input type="checkbox"/> Renal (Kidneys) <input type="checkbox"/> Retroperitoneal <input type="checkbox"/> Scrotum <input type="checkbox"/> Scrotum w/ color dop.	<input type="checkbox"/> Thyroid <input type="checkbox"/> Transvaginal <input type="checkbox"/> Venous Doppler (DVT) R L Bilat  <b>US Guided Biopsy</b> <input type="checkbox"/> Breast Biopsy Right—Left <input type="checkbox"/> Breast Aspiration Right—Left <input type="checkbox"/> Thyroid Biopsy	<b>EVLT / Sclerotherapy</b> <input type="checkbox"/> Consult for EVLT (Consult / DVT Ultrasound)  <input type="checkbox"/> Consult for Sclero (Consult /DVT Ultrasound)  <input type="checkbox"/> EVLT  <input type="checkbox"/> Sclerotherapy  <input type="checkbox"/> Consult / Follow up	<b>Nuclear Medicine</b> <input type="checkbox"/> Bone Scan - <input type="checkbox"/> I 131 Therapy 3 phase <input type="checkbox"/> MUGA <input type="checkbox"/> Bone Scan - <input type="checkbox"/> Renal -(F&F) Whole body/spec (Captopril) <input type="checkbox"/> Brain Spect <input type="checkbox"/> Renal - (Lasix) <input type="checkbox"/> Cardiac <input type="checkbox"/> Thyroid Uptake <input type="checkbox"/> Gallium <input type="checkbox"/> WBC <input type="checkbox"/> Gastric Empty <input type="checkbox"/> Hemangioma <input type="checkbox"/> Other <input type="checkbox"/> Hepatobiliary <input type="checkbox"/> Liver /Spleen/ Spec <input type="checkbox"/> Lung Scan
		<b>MRI</b> <b>Please Select:</b> <input type="checkbox"/> w/o Gad or <input type="checkbox"/> w/wo Gad <input type="checkbox"/> Abdomen <input type="checkbox"/> Brachial Plexus <input type="checkbox"/> Brain <input type="checkbox"/> Breast Bi / L / R <input type="checkbox"/> Cervical <input type="checkbox"/> Chest <input type="checkbox"/> Fibroid Pelvis <input type="checkbox"/> IAC's <input type="checkbox"/> Lumbar <input type="checkbox"/> Orbits <input type="checkbox"/> Pelvis (Bony / Soft) <input type="checkbox"/> Pituitary <input type="checkbox"/> Prostate <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Thoracic <input type="checkbox"/> Trigeminal	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Ankle <input type="checkbox"/> Elbow <input type="checkbox"/> Femur <input type="checkbox"/> Foot <input type="checkbox"/> Forearm <input type="checkbox"/> Hand <input type="checkbox"/> Hip <input type="checkbox"/> Humerus <input type="checkbox"/> Knee <input type="checkbox"/> Shoulder <input type="checkbox"/> Wrist <input type="checkbox"/> MR Arthrogram	<b>CAT Scan</b> <b>Please Select:</b> <input type="checkbox"/> w/ Contrast or <input type="checkbox"/> w/o Contrast <input type="checkbox"/> w/wo Contrast <input type="checkbox"/> Abd <input type="checkbox"/> Abd / Pel (Stone) <input type="checkbox"/> CT Coronary Angio <input type="checkbox"/> Abd/ Pel <input type="checkbox"/> CT Virtual Colon <input type="checkbox"/> Brain <input type="checkbox"/> Chest <input type="checkbox"/> CT Guided Biopsy <input type="checkbox"/> Chest w/ contrast <input type="checkbox"/> Chest /Abd/Pel <input type="checkbox"/> Leg Lengths <input type="checkbox"/> Lumbar w/ 3D <input type="checkbox"/> Facial w/3D <input type="checkbox"/> Orbits w/ 3D <input type="checkbox"/> Pelvis <input type="checkbox"/> Sinus <input type="checkbox"/> Sinus w/ Insta <input type="checkbox"/> ST Neck <input type="checkbox"/> Temporal w/ 3D  <b>Other:</b> _____ <input type="checkbox"/> 3D Recon, if needed	

**1-888-XRAY-888**  
**845-454-4700**  
**FAX: 845-454-5128**