

Diagnostic Imaging Order Form

817-759-7068 ph.

817-759-7069 fax

PATIENT INFORMATION

Name: _____ DOB: _____ Weight: (lbs) _____ M | F

Patient Phone: _____ Social Security: _____

Insurance: _____ Group#: _____ ID# _____

Ordering Physician: _____ Signature: _____

Phone Number: _____ Fax Number: _____

Reason for Exam: _____

ICD-10 Code: _____

Physician Preference for Results: Report Only Report and CD Routine STAT

<input type="checkbox"/> MRI <input type="checkbox"/> With IV Contrast <input type="checkbox"/> Without IV Contrast <input type="checkbox"/> With and Without IV Contrast <input type="checkbox"/> Patient is Claustrophobic	<input type="checkbox"/> Brain MRI <input type="checkbox"/> Brain MRV <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Knee Left <input type="checkbox"/> Knee Right <input type="checkbox"/> Other (Specify): _____ <input type="checkbox"/> Implants <input type="checkbox"/> Pacemaker <input type="checkbox"/> Stents <input type="checkbox"/> A-Clip/Coils Creatinine: _____ GFR: _____ Date: _____
<input type="checkbox"/> CT <input type="checkbox"/> With IV Contrast <input type="checkbox"/> Without IV Contrast <input type="checkbox"/> With and Without IV Contrast	<input type="checkbox"/> Head CT <input type="checkbox"/> Sinus <input type="checkbox"/> Chest <input type="checkbox"/> Extremity (Specify): _____ <input type="checkbox"/> Abdomen and Pelvis <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Renal colic <input type="checkbox"/> Spine: <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> CTA (Specify): _____ Creatinine: _____ GFR: _____ Date: _____
<input type="checkbox"/> PET/CT	<input type="checkbox"/> Posluma PSMA <input type="checkbox"/> PET/CT Skull Base to mid-thigh <input type="checkbox"/> PET/CT Dotatate (Neuroendocrine) <input type="checkbox"/> PET/CT PSMA <input type="checkbox"/> PET/CT Whole Body 78816 (Multiple Myeloma or Melanoma) <input type="checkbox"/> FDG Brain Scan <input type="checkbox"/> PET/CT Amyloid Plaque
<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Complete Abdomen <input type="checkbox"/> Limited Abdomen (Specify): _____ <input type="checkbox"/> Pelvis <input type="checkbox"/> OB <input type="checkbox"/> Renal <input type="checkbox"/> Scrotum <input type="checkbox"/> Thyroid <input type="checkbox"/> Thyroid FNA <input type="checkbox"/> Cartoid <input type="checkbox"/> AAA <input type="checkbox"/> Venous (DVT) Lower Extremity (<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral) Upper Extremity (<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral) <input type="checkbox"/> Arterial <input type="checkbox"/> US PVS <input type="checkbox"/> ABI Only <input type="checkbox"/> Full Peripheral <input type="checkbox"/> Lower Extremity (<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral) <input type="checkbox"/> Upper Extremity (<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral) <input type="checkbox"/> Other (Specify): _____
<input type="checkbox"/> Nuclear Medicine	<input type="checkbox"/> Whole Bone Scan <input type="checkbox"/> Thyroid (Uptake and Scan) <input type="checkbox"/> MUGA <input type="checkbox"/> Three Phase Bone Scan <input type="checkbox"/> Gastric Emptying <input type="checkbox"/> Multiple Areas Bone Scan <input type="checkbox"/> HIDA <input type="checkbox"/> HIDA (with ejection fraction) <input type="checkbox"/> Renal Scan (<input type="checkbox"/> Lasix <input type="checkbox"/> MAG3) <input type="checkbox"/> Other (Specify): _____

Preparations- Please follow Carefully. Call the Department with any questions.

MRI	<ul style="list-style-type: none">• Claustrophobic patients- contact your physician regarding pre-exam medication. You will need to arrange a ride home.• Abdomen and Pelvis: Noting to Eat or Drink for 4 hours prior to exam
CT	<ul style="list-style-type: none">• Nothing to eat for 4 hours prior to exam• Nothing to drink for 2 hours prior to exam
PET/CT	<ul style="list-style-type: none">• Nothing to eat for 12 hours prior to exam
Ultrasound	<ul style="list-style-type: none">• Abdomen: Nothing to eat or drink for 8 hours prior to exam• OB, Pelvis or Renal: Start by emptying bladder 2 hours before appointment, then drink 32 ounces of water, finish 1 hour before appointment
Nuclear Medicine	<ul style="list-style-type: none">• Nothing to eat or drink for 8 hours prior to exam for:<ul style="list-style-type: none">— Gastric emptying— Thyroid uptake and scan— HIDA scan— PET/CT• HIDA scan: No opiates or narcotics 6 hours prior to exam

The following MUST accompany the referral form:

- Patient Demographics/ Insurance Card
- Recent imaging if available (modality, date, location) disc if available
- CMP/CBC if available
- CPT Code
- Office Visit Note
- Reason for exam e.g. (abdominal pain, disease progression, etc.)

Locations:

<input type="checkbox"/> Arlington (CT Scans Only) 515 W. Mayfield Rd Suite 102 Arlington, TX 76014	<input type="checkbox"/> Las Colinas (CT, PET/CT) 7415 Las Colinas Blvd Suite 100 Irving, TX 75063	<input type="checkbox"/> Weatherford (CT scan, Dexa scan) 920 Santa Fe Dr Weatherford, TX 76086
<input type="checkbox"/> Burleson (CT Scans only) 11805 South Freeway Suite 201 Burleson, TX 76028-7220	<input type="checkbox"/> Magnolia (CT, MRI , US, NM, X-Ray, PET/CT) 800 West Magnolia Ave Fort Worth, TX 76104	<input type="checkbox"/> Mesquite (CT, PET/CT) 2698 N. Galloway Mesquite, TX 75150
<input type="checkbox"/> Denton (CT, PET/CT) 2900 N I-35 Ste 111 Denton, TX 76201-5142	<input type="checkbox"/> Southlake (CT, MRI, X-Ray) 630 E State Highway 114 Southlake, TX 76092	<input type="checkbox"/> McKinney (PET/CT) 4201 Medical Center Dr, Suite 180 McKinney, TX 75069