Patient Name: ______________________ D.O.B. ________________

Patient Phone: ______________________ Email: ______________________

Appointment Date: ________________ Time ______ A.M. ______ P.M.

Physician: ________________________ Physician’s Signature: ________________________

Diagnosis: ________________________

Physician’s Phone #: ______________________ Fax #: ______________________

☐ Please return patient to my office
☐ Written Report
☐ Please send film or CD with patient
☐ Please send films to my office
☐ Stat report requested

PLEASE INCLUDE THE FOLLOWING INFORMATION FOR INSURANCE VERIFICATION & PRE-VERIFICATION:

Primary Insurance/WC ______________________ Phone: ______________________ ID/Case #: ______________________

☐ Precert Request: Please fax order, patient demographic, insurance, Lab and clinical notes to 334-777-1811. Physician’s NPI# ________________

Tax ID# ______________________

☐ If you have precerted, please supply auth # here ________________

Please bring this referral sheet with you as well as insurance cards and ID card (Driver’s license, military ID, etc.) and a compact disc or cassette of your favorite music to listen to during your scan. Wear comfortable clothing, free of metal, if possible, and remove all jewelry. There are no dietary restrictions for MRI.

MRI- Magnetic Resonance Imaging
Choose Machine: _____ Open _____ 1.5T short bore

☐ ABD
☐ Brain ______ w/o contrast
☐ IAC’s ______ w & w/o contrast
☐ Orbits ______ w contrast
☐ Pituitary
☐ Cervical Spine ______ Head
☐ Thoracic Spine ______ Neck
☐ Lumbar Spine ______ ABD
☐ Pelvis ______ Pelvis
☐ Hip Right Left
☐ Shoulder Right Left
☐ Knee Right Left
☐ Wrist Right Left
☐ Lower extremity Right Left
☐ Upper extremity Right Left
☐ Other

Pre-study Lab Testing
☐ Bun/Creatinine

CT- Computerized Tomography
If the patient is having a test requiring contrast please note the following:
1. Diabetic patients taking Glucophage or Metformin may not resume medication for 48 hours after their exam. A BUN and CREATININE must be obtained prior to exam and then re-checked before continuing Glucophage or Metformin.
2. If the patient is over 60 or she needs to obtain a BUN and Creatinine study. Bun Creat Date Drawn
3. Please notify if the patient has renal or heart problems.

☐ BRAIN With or Without
☐ SINUS
☐ IAC’s
☐ FACIAL BONES
☐ CT OTHER

ROUTINE ABDOMEN/PELVIS With or Without
STONE SEARCH PROTOCOL ABDOMEN/PELVIS Without

☐ ABDOMEN With or Without
☐ PELVIS With or Without

3 PHASE ABDOMEN

ROUTINE CHEST WITH ROUTINE CHEST WITH OUT

☐ SPINE With or Without

☐ CERVICAL ☐ THORACIC ☐ LUMBAR

Prep/pick-up Oral Prep the day before the exam from HTIC Imaging Center

CTA ☐

SPECIAL INSTRUCTIONS:

Diagnostic Routine X-Rays

☐ Chest
☐ Abdomen Series
☐ KUB
☐ Ribs
☐ Skull
☐ Sinuses
☐ Cervical Spine
☐ Thoracic Spine
☐ Lumbar Spine
☐ Pelvis

☐ Extremity R or L

☐ Other

☐ Extremity R or L

SPECIAL INSTRUCTIONS:

Ultrasound

☐ ABV/Segmental Pressure
☐ Complete Abdomen (aorta, liver, GB, pancreas, spleen, bilateral kidneys) PREP: Nothing to eat or drink after midnight

☐ Limited Abdomen (GB, Liver, Pancreas) PREP: Nothing to eat or drink after midnight

☐ Renal PREP: Nothing to eat or drink after midnight

☐ Pelvis PREP: Drink at least 32 oz fluid on hour before exam. Do not void.

☐ Carotid

☐ Lower Extremity Venous Doppler: (Please circle) Bilateral Unilateral

☐ Lower Ext Arterial Doppler/ABI’s

☐ OB

☐ Other

☐ Echo

SPECIAL INSTRUCTIONS: