



Med-Tech Imaging Center

102 Medical Center Drive • Suite B • Prattville, AL 36066

Tel. 334-358-1666 • Fax 334-777-1811

Innovation Drives Us • Competition Guides Us



Patient Name: _____ D.O.B. _____

Patient Phone: _____ Email: _____

Appointment Date: _____ Time _____ A.M. P.M.

Physician _____ Physician's Signature: _____

Diagnosis: _____

Physician's Phone # _____ Fax # _____

____ Return patient to my office _____ Written Report

____ Please send film or CD with patient _____ Please send films to my office

____ Stat report requested

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.

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 _____

MRI- Magnetic Resonance Imaging

Choose Machine: _____ Open _____ 1.5T shortbore

- _____ ABD
- _____ Brain _____ w/o contrast
- _____ IAC's _____ w & w/o contrast
- _____ Orbits _____ w contrast
- _____ Pituitary **MRA**
- _____ 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:

- 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.
- If the patient is over 60 he or she needs to obtain a BUN and **Creatinine** study. Bun _____ Creat _____ Date Drawn _____
- 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 With or Without
- 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 _____
- Ribs R or L _____
- _____
- Other _____
- Extremity R or L _____

SPECIAL INSTRUCTIONS:

Ultrasound

- ABISegmental 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: _____

