



PRESCRIPTION

Patient: _____ Date: _____ Referring Physician: _____
 Phone (Home): _____ Physician's Signature: _____
 Phone (Cell): _____ Phone: _____
 Diagnosis & Special Instructions: _____ Fax: _____
 _____ STAT-Call with Report _____
 ICD-9: _____ Send Films or CD Fax Report
 _____ Copy of Report to: _____

COMPUTED TOMOGRAPHY (CT SCAN)	MRI	ULTRASOUND - BODY & SMALL PARTS
Abdomen And Pelvis (*) <input type="checkbox"/> Abdomen / Pelvis - { Abdomen with/without Pelvis with <input type="checkbox"/> Abdomen / Pelvis with only <input type="checkbox"/> Abdomen with and without <input type="checkbox"/> With Only <input type="checkbox"/> Without Only <input type="checkbox"/> Pelvis with Contrast <input type="checkbox"/> With and without <input type="checkbox"/> Without Only <input type="checkbox"/> Stone Protocol (No Oral or IV Contrast) Head and Neck <input type="checkbox"/> Brain/Head <input type="checkbox"/> Sinus <input type="checkbox"/> Facial Bones <input type="checkbox"/> Orbits <input type="checkbox"/> Neck Chest <input type="checkbox"/> Chest Contrast <input type="checkbox"/> With / without* <input type="checkbox"/> Without <input type="checkbox"/> Radiologist Discretion* <input type="checkbox"/> With Only* Spine and Extremities <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Extremity _____ <input type="checkbox"/> 3D/Multiplanar Reconstruction* Cardiovascular <input type="checkbox"/> Cardiac Scoring <input type="checkbox"/> CT Angiography Carotids with MPR* <input type="checkbox"/> Without MPR <input type="checkbox"/> CT Angiography Aorta with MPR* <input type="checkbox"/> Without MPR <input type="checkbox"/> CT Angiography of the Pulmonary Arteries (P.E. study) with MPR* <input type="checkbox"/> Without MPR DEXA (DXA, DUAL ENERGY X-RAY ABSORPTIOMETRY) <input type="checkbox"/> Dexam X-RAY <input type="checkbox"/> Chest PA and Lateral <input type="checkbox"/> Rib Series with PA Chest L / R / Bilat <input type="checkbox"/> Without PA Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Hip with Pelvis L / R <input type="checkbox"/> Hip Only L / R <input type="checkbox"/> Spine, Cervical <input type="checkbox"/> Spine, Thoracic <input type="checkbox"/> Spine, Lumbar <input type="checkbox"/> Sinus Series, 3 or More Views <input type="checkbox"/> Skull Series, 4views <input type="checkbox"/> Extremity: _____ <input type="checkbox"/> Other: _____	Head/Spine <input type="checkbox"/> Brain <input type="checkbox"/> Orbits <input type="checkbox"/> IACs/Temporal Bone with MPR* { * High resolution of cranial nerves <input type="checkbox"/> IAC without MPR <input type="checkbox"/> Pituitary <input type="checkbox"/> Sinuses <input type="checkbox"/> Temporomandibular Joint <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Sacrum Musculoskeletal <input type="checkbox"/> Shoulder L / R <input type="checkbox"/> Elbow with MPR* L / R <input type="checkbox"/> Elbow without MPR <input type="checkbox"/> Wrist with MPR* { * High resolution of ligaments and tendons L / R <input type="checkbox"/> Wrist without MPR { * High resolution of ligaments and TFC L / R <input type="checkbox"/> Hand L / R <input type="checkbox"/> Hip <input type="checkbox"/> Pelvis <input type="checkbox"/> Knee with MPR* { * High resolution of menisci and ligaments L / R <input type="checkbox"/> Knee without MPR <input type="checkbox"/> Ankle/Hindfoot L / R <input type="checkbox"/> Forefoot L / R Body <input type="checkbox"/> Neck - Soft Tissue <input type="checkbox"/> Liver <input type="checkbox"/> Pancreas / MRCP* <input type="checkbox"/> Kidneys <input type="checkbox"/> Pelvis - Soft Tissue <input type="checkbox"/> Other _____ Contrast <input type="checkbox"/> With / without* <input type="checkbox"/> Without <input type="checkbox"/> Radiologist Discretion* <input type="checkbox"/> With Only* MR Arthrography / Arthrogram <input type="checkbox"/> Arthrogram then MR Shoulder L / R <input type="checkbox"/> Arthrogram then MR Elbow with MPR L / R <input type="checkbox"/> Elbow MR without MPR <input type="checkbox"/> Arthrogram then MR Wrist with MPR L / R <input type="checkbox"/> Wrist MR without MPR <input type="checkbox"/> Arthrogram then MR Hip L / R <input type="checkbox"/> Other _____ MR Angiography (MRA) <input type="checkbox"/> Brain / Circle of Willis <input type="checkbox"/> Carotid <input type="checkbox"/> Thoracic Aorta <input type="checkbox"/> Abdominal Aorta <input type="checkbox"/> Renal Arteries <input type="checkbox"/> Abdomen / Run Off Extremities MPR= Multiplanar Reconstruction THIN SECTION MULTIPLANAR IMAGES FOR HIGHER SENSITIVITY	<input type="checkbox"/> *Abdomen Including Retroperitoneum <input type="checkbox"/> Abdomen Only <input type="checkbox"/> Single Organ (Eg, gallbladder): _____ <input type="checkbox"/> *Retroperitoneum <input type="checkbox"/> Kidneys Only <input type="checkbox"/> *Aorta <input type="checkbox"/> *Pelvis with Transvaginal <input type="checkbox"/> Pelvis Only <input type="checkbox"/> Transvaginal Only <input type="checkbox"/> Thyroid <input type="checkbox"/> Breast <input type="checkbox"/> Scrotum, with Doppler <input type="checkbox"/> Scrotum without Doppler <input type="checkbox"/> Other _____ ULTRASOUND - CARDIOVASCULAR <input type="checkbox"/> Carotid Doppler, Bilateral <input type="checkbox"/> Venous Lower Extremity / DVT, Bilateral <input type="checkbox"/> Unilateral: L / R <input type="checkbox"/> Venous Upper Extremity L / R / Bilateral <input type="checkbox"/> Arterial, Non Invasive, Lower Extremities <input type="checkbox"/> With Duplex if Abnormal ABI <input type="checkbox"/> Arterial, Non Invasive, Upper Extremities <input type="checkbox"/> With Duplex if Abnormal BI <input type="checkbox"/> Echocardiogram 2D/M Mode with Doppler & Color Flow <input type="checkbox"/> Echocardiogram 2D/M Mode Only NUCLEAR MEDICINE Bone Scan <input type="checkbox"/> Bone Scan, Triple (3) Phase, with SPECT <input type="checkbox"/> Bone Scan with SPECT <input type="checkbox"/> Bone Scan without SPECT Cardiac <input type="checkbox"/> Myocardial Perfusion - Complete, Treadmill <input type="checkbox"/> Gated with No Wall Motion or EF <input type="checkbox"/> Myocardial Perfusion - Complete, Pharmacologic <input type="checkbox"/> Gated with No Wall Motion or EF <input type="checkbox"/> Cardiac Muga (Multigated Acquisition) Scan Body <input type="checkbox"/> Thyroid Scan and Uptake (I-123) <input type="checkbox"/> Thyroid Scan Only <input type="checkbox"/> Thyroid Therapy (I-131) Dose _____ <input type="checkbox"/> Parathyroid with SPECT <input type="checkbox"/> Parathyroid without SPECT <input type="checkbox"/> Hepatobiliary Scan with EF <input type="checkbox"/> Liver-spleen Scan with SPECT <input type="checkbox"/> Liver-spleen Scan, Planar Only <input type="checkbox"/> Hemangioma Liver RBC Scan with SPECT <input type="checkbox"/> Hemangioma Scan without SPECT <input type="checkbox"/> Gastric Emptying Scan <input type="checkbox"/> Brain SPECT Scan <input type="checkbox"/> Lung Scan (Perfusion Only, Quantitative) <input type="checkbox"/> White Blood Cell Scan with SPECT <input type="checkbox"/> White Blood Cell Scan without SPECT <input type="checkbox"/> Other: _____

INSTRUCTIONS TO PATIENT

1. Arrive 30 minutes prior to your scheduled appointment.
2. Bring your insurance card and any other insurance information.
3. Please call at least 24 hours prior to your appointment if you need to reschedule. T: 239.333.ARIA (2742).
4. Please bring this Prescription with you or your appointment may have to be rescheduled.

PREPARATION INSTRUCTIONS

ULTRASOUND PREPARATION:

Abdomen, Retroperitoneum, Aorta, including single organs (gallbladder, pancreas, spleen): Nothing to eat, drink or chew for 8 hours prior to exam.

Pelvis: Drink several glasses of water 1-2 hours prior to the exam. Do not urinate prior to the exam. A full bladder is required for the examination.

MRI PREPARATION:

MRI abdomen, pancreas/MRCP: Nothing to eat, drink or chew for 6 hours prior to exam.

COMPUTED TOMOGRAPHY (CT) SCAN PREPARATION:

(*) Abdomen/pelvis studies: 1 bottle of oral contrast 2 hours prior, and 1 bottle 30 minutes prior to exam time

(**) Study with intravenous contrast: nothing to eat, drink or chew for 3 hours prior to exam time; except abdomen and pelvis (see above)

