



3365 G Street Suite 100
 Merced CA 95340
 Phone: (209) 384-2121
 FAX: (209) 384-4269

Patient Name _____ Date of Birth _____
 Appointment Date _____ Time _____
 Referring Provider _____
 Office Phone () _____ Fax () _____

SPECIAL INSTRUCTIONS

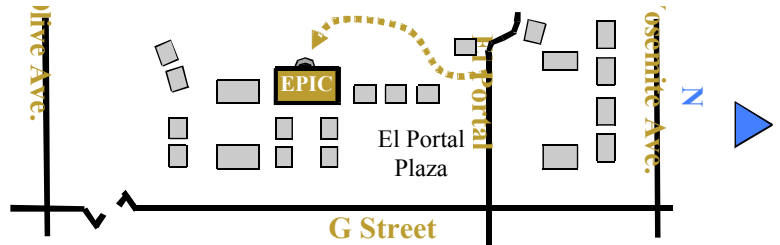
Routine Phone Report Fax Report ASAP STAT Please provide **PHONE NUMBER** for use **AFTER 5 PM** _____

Diagnosis/History: _____

MRI			
BRAIN <input type="checkbox"/> without Contrast <input type="checkbox"/> without & with Contrast	CERVICAL SPINE <input type="checkbox"/> without Contrast <input type="checkbox"/> without & with Contrast	<input type="checkbox"/> KNEE Right / Left <input type="checkbox"/> SHOULDER Right / Left <input type="checkbox"/> ANKLE Right / Left	<input type="checkbox"/> ABDOMEN (includes liver, spleen, pancreas, gallbladder) <input type="checkbox"/> KIDNEYS <input type="checkbox"/> MRCP <input type="checkbox"/> PELVIS <input type="checkbox"/> MRA Abdominal Aorta <input type="checkbox"/> MRA Abdominal Aorta w/runoff <input type="checkbox"/> MRA Renals OTHER _____
<input type="checkbox"/> MRA Circle of Willis <input type="checkbox"/> MRA Carotids <input type="checkbox"/> IAC's <input type="checkbox"/> PITUITARY <input type="checkbox"/> NECK SOFT TISSUE	THORACIC SPINE <input type="checkbox"/> without Contrast <input type="checkbox"/> without & with Contrast	<input type="checkbox"/> HIP Right / Left <input type="checkbox"/> ELBOW Right / Left <input type="checkbox"/> WRIST Right / Left <input type="checkbox"/> TMJ's <input type="checkbox"/> BREAST Unilateral Right / Left <input type="checkbox"/> BREAST Bilateral	
CT			
BRAIN <input type="checkbox"/> without Contrast (only) <input type="checkbox"/> without & with Contrast	CHEST <input type="checkbox"/> without Contrast <input type="checkbox"/> without & with Contrast	ABDOMEN (Routine) <input type="checkbox"/> without Contrast <input type="checkbox"/> without & with Contrast	<input type="checkbox"/> CERVICAL SPINE <input type="checkbox"/> THORACIC SPINE <input type="checkbox"/> LUMBAR SPINE <input type="checkbox"/> JOINT: Right / Left (specify joint) <input type="checkbox"/> BONE: Right / Left (specify bone) <input type="checkbox"/> OTHER:
<input type="checkbox"/> SINUSES <input type="checkbox"/> MASTOIDS <input type="checkbox"/> ORBITS <input type="checkbox"/> FACIAL BONES	<input type="checkbox"/> CHEST (High Resolution) <input type="checkbox"/> CHEST (Pulm. Embolus) <input type="checkbox"/> THORACIC AORTA <input type="checkbox"/> ABDOMINAL AORTA <input type="checkbox"/> NECK (Routine)	PELVIS <input type="checkbox"/> without Contrast <input type="checkbox"/> without & with Contrast	
Nuclear Medicine			
<input type="checkbox"/> BONE SCAN <input type="checkbox"/> HEPATOBILIARY (HIDA) <input type="checkbox"/> RENAL SCAN (DTPA) <input type="checkbox"/> with captopril	<input type="checkbox"/> LIVER / SPLEEN <input type="checkbox"/> MUGA scan <input type="checkbox"/> GASTRIC emptying dual phase	<input type="checkbox"/> THYROID scan only <input type="checkbox"/> THYROID scan with Uptake <input type="checkbox"/> PARATHYROID scan	<input type="checkbox"/> LUNG Ventilation/Perfusion <input type="checkbox"/> OTHER
PET (please indicate if exam is for) Diagnosis ___ Staging ___ Restaging ___			
<input type="checkbox"/> BREAST CANCER <input type="checkbox"/> LYMPHOMA	<input type="checkbox"/> COLORECTAL CANCER <input type="checkbox"/> MELANOMA	<input type="checkbox"/> HEAD & NECK CANCER <input type="checkbox"/> THYROID	<input type="checkbox"/> LUNG CANCER <input type="checkbox"/> BRAIN
Diagnostic Radiology (Specify body part including R,L, and Bilateral)			
<input type="checkbox"/> CHEST 1V <input type="checkbox"/> CHEST 2V <input type="checkbox"/> RIBS Right / Left / Bilateral <input type="checkbox"/> NECK Soft Tissues <input type="checkbox"/> SINUS SERIES <input type="checkbox"/> ABDOMEN 1V <input type="checkbox"/> ABDOMEN 2V <input type="checkbox"/> C-SPINE (complete) <input type="checkbox"/> C-SPINE (limited)	<input type="checkbox"/> T-SPINE <input type="checkbox"/> L-SPINE (complete) <input type="checkbox"/> L-SPINE (limited) <input type="checkbox"/> SACRUM/COCCYX <input type="checkbox"/> SI JOINTS <input type="checkbox"/> SCOLIOSIS SERIES <input type="checkbox"/> BONE SURVEY <input type="checkbox"/> BONE AGE <input type="checkbox"/> STERNUM <input type="checkbox"/> CLAVICLE	<input type="checkbox"/> HIP Right / Left <input type="checkbox"/> FEMUR Right / Left <input type="checkbox"/> KNEE Right / Left <input type="checkbox"/> TIBIA/FIBULA Right / Left <input type="checkbox"/> ANKLE Right / Left <input type="checkbox"/> FOOT Right / Left <input type="checkbox"/> OS CALCIS Right / Left <input type="checkbox"/> TOES Right / Left <input type="checkbox"/> SKULL <input type="checkbox"/> ORBITS <input type="checkbox"/> FACIAL BONES	<input type="checkbox"/> NASAL BONES <input type="checkbox"/> MANDIBLE <input type="checkbox"/> SHOULDER Right / Left <input type="checkbox"/> HUMERUS Right / Left <input type="checkbox"/> ELBOW Right / Left <input type="checkbox"/> FOREARM Right / Left <input type="checkbox"/> WRIST Right / Left <input type="checkbox"/> HAND Right / Left <input type="checkbox"/> FINGERS Right / Left <input type="checkbox"/> OTHER
Ultrasound			
<input type="checkbox"/> ABDOMEN <input type="checkbox"/> RENAL <input type="checkbox"/> PELVIS <input type="checkbox"/> PELVIS with EV	<input type="checkbox"/> OB <input type="checkbox"/> THYROID <input type="checkbox"/> TESTICULAR <input type="checkbox"/> CAROTID	<input type="checkbox"/> AORTA PERIPHERAL VASCULAR <input type="checkbox"/> VENOUS Upper / Lower Right / Left <input type="checkbox"/> ARTERIAL Upper / Lower Right / Left	<input type="checkbox"/> BREAST Right / Left <input type="checkbox"/> OTHER
Mammography			
<input type="checkbox"/> SCREENING	<input type="checkbox"/> DIAGNOSTIC	<input type="checkbox"/> UNILATERAL Right / Left	<input type="checkbox"/> OTHER

Provider Signature _____ Date _____

Important Patient information on the back of this form.



Instructions

- Be sure to follow instructions for your exam preparation. Please bring the following items with you to your appointment
 - α Insurance card
 - α Physician's order
 - α Prior imaging/x-ray/mammogram examination
- Please be sure any precertification requirements of your healthplan are met prior to your appointment.
- Please arrive at least 20 minutes prior to your appointment.
- Exam results will be sent to your physician within 48 hours.
- If you need to check out your x-rays, please call us 24 hours in advance.
- If you have any questions about preparation or your exam, please contact us at the phone number listed above.

Exam Preparations

- **MRI:**
 - α Assure that you **Do NOT** have a pacemaker or brain aneurysm clip. Notify staff if you have any metal anywhere in your body. Please arrive well-hydrated (2-4 glasses of water) as some exams may require an IV contrast injections.
- **CT ****
 - α Please drink 4-6 glasses of water starting four hours prior to your exam. **Do NOT** eat anything for at least four hours prior to the exam.
- **NUCLEAR MEDICINE & PET EXAMINATIONS**
 - α Please call office for exam instructions.
- **XRAY**
 - α Please call office for exam instructions.
- **ULTRASOUND**
 - α **ABDOMEN /GALLBLADDER/ KIDNEY/AORTA ULTRASOUND:** Please eat a **FAT FREE meal** the evening before your exam. **Do NOT** eat or drink anything after midnight prior to the exam.
 - α **PELVIC/OB ULTRASOUND:** Drink 4 glasses of water one hour prior to appointment. **Do NOT** empty bladder. Bladder must be full for exam.
- **MAMMOGRAM:**
 - α **Do NOT** use deodorant, powder, or perfume prior to exam.

****** If you **ALLERGIC to IODINE** or **IVP DYE**,
notify our office **PRIOR** to your appointment

****** If you are **DIABETIC**, **Do NOT** take **GLUCOPHAGE**
for **48 HOURS AFTER** your exam