

IMAGING CENTER PHYSICIAN'S ORDER FORM

PATIENT NAME _____ D.O.B. _____ DATE _____

DIAGNOSIS CODE (ICD-9) (REQUIRED) _____ TEL _____

WRITTEN DIAGNOSIS (REQUIRED, NO RULE OUT, VERSUS OR PROBABLE) _____

PHYSICIAN'S SIGNATURE (REQUIRED, NO SIGNATURE STAMPS) _____ M.D.

CALL PRELIMINARY READING TEL # _____ AFTER HOURS TEL # _____

PATIENT INSURANCE _____ POLICY# _____ GROUP# _____

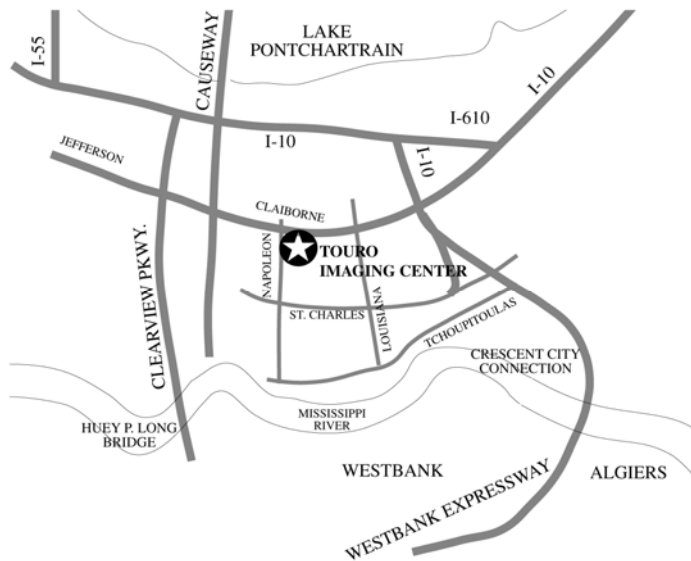
AUTHORIZATION # _____ REFERRING PHYSICIAN (PLEASE PRINT) _____ M.D.

ADDRESS _____ TEL _____ FAX _____

Legend: W = with, W/O = without

<p>CT SCAN</p> <p><input type="checkbox"/> HEAD <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> SOFT T-NECK <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> CHEST <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> CHEST HI RES <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> ABDOMEN <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> PELVIS <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> SINUSES <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> IAC <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> TEMP BONE <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> ORBITS <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> FACIAL <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> C SPINE <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> L SPINE <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> T SPINE <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> OTHER _____</p> <p>CTA</p> <p><input type="checkbox"/> CAROTID <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> AORTA <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> HEAD <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> PELVIS <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> UPPER EXT <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> LOWER EXT <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> RUNOFF <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> OTHER _____</p> <p>PET/CT</p> <p><input type="checkbox"/> WHOLE BODY - MELANOMA/SARCOMA ONLY</p> <p><input type="checkbox"/> SKULL TO THIGH</p> <p><input type="checkbox"/> BRAIN</p> <p><input type="checkbox"/> OTHER _____</p> <p>SPECIAL PROCEDURES</p> <p><input type="checkbox"/> ARTHROGRAM <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> MR <input type="checkbox"/> CT</p> <p><input type="checkbox"/> ESI (LUMBAR)</p> <p><input type="checkbox"/> HIP INJECTION <input type="checkbox"/> R <input type="checkbox"/> L</p>	<p>MRI</p> <p>HEAD</p> <p><input type="checkbox"/> BRAIN <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> IAC <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> ORBIT <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> PITUITARY GLAND <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> FACIAL <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> OTHER _____</p> <p>BODY</p> <p><input type="checkbox"/> NECK <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> CHEST <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> BREAST <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> PELVIS <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> GYN PELVIS <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> MRCP <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> KIDNEYS <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> ADRENALS <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> LIVER <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> OTHER _____</p> <p>SPINE</p> <p><input type="checkbox"/> CERVICAL SPINE <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> THORACIC SPINE <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> LUMBAR SPINE <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> BRACHIAL PLEXUS <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p>JOINT</p> <p><input type="checkbox"/> UPPER EXT <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> LOWER EXT <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> ARTHROGRAPHY BODY PART _____</p> <p>NON-JOINT</p> <p><input type="checkbox"/> UPPER EXT <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> LOWER EXT <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> W <input type="checkbox"/> W/O</p> <p><input type="checkbox"/> OTHER _____</p> <p>MRA</p> <p><input type="checkbox"/> BRAIN</p> <p><input type="checkbox"/> NECK</p> <p><input type="checkbox"/> ABDOMEN</p> <p><input type="checkbox"/> CHEST</p> <p><input type="checkbox"/> PELVIS</p> <p><input type="checkbox"/> EXTREMITY RUNOFF <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> OTHER _____</p>	<p>X-RAY</p> <p><input type="checkbox"/> CHEST (1VIEW)</p> <p><input type="checkbox"/> CHEST (2 VIEW)</p> <p><input type="checkbox"/> KUB</p> <p><input type="checkbox"/> ABDOMEN FLAT & ERECT</p> <p><input type="checkbox"/> SKULL</p> <p><input type="checkbox"/> SINUSES</p> <p><input type="checkbox"/> ORBITS</p> <p><input type="checkbox"/> FACIAL BONES</p> <p><input type="checkbox"/> CERVICAL SPINE</p> <p><input type="checkbox"/> THORACIC SPINE</p> <p><input type="checkbox"/> LUMBAR SPINE</p> <p><input type="checkbox"/> W/ FLEX & EXT</p> <p><input type="checkbox"/> W/ OBLIQUES</p> <p><input type="checkbox"/> FLEX & EXT ONLY</p> <p><input type="checkbox"/> SACRUM/COCCYX</p> <p><input type="checkbox"/> PELVIS</p> <p><input type="checkbox"/> OTHER _____</p> <p><input type="checkbox"/> FINGERS <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> HAND <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> WRIST <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> FOREARM <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> ELBOW <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> HUMERUS <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> SHOULDER <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> SCAPULA <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> CLAVICLE <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> RIBS <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> HIP <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> FEMUR <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> KNEE <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> PATELLA <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> TIB / FIB <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> ANKLE <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> FOOT <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> TOE <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> IVP</p> <p><input type="checkbox"/> OTHER _____</p> <p>FLUOROSCOPY</p> <p><input type="checkbox"/> ESOPHOGRAM</p> <p><input type="checkbox"/> UGI</p> <p><input type="checkbox"/> SMALL BOWEL</p> <p><input type="checkbox"/> BE</p> <p><input type="checkbox"/> BE WITH AIR</p> <p><input type="checkbox"/> OTHER _____</p>	<p>ULTRASOUND</p> <p><input type="checkbox"/> UPPER ABDOMEN</p> <p><input type="checkbox"/> LIMITED ABD _____</p> <p><input type="checkbox"/> GALL BLADDER</p> <p><input type="checkbox"/> APPENDIX</p> <p><input type="checkbox"/> SOFT TISSUE _____</p> <p><input type="checkbox"/> DOPPLER PORTAL VEIN</p> <p><input type="checkbox"/> PELVIS NON OB</p> <p><input type="checkbox"/> TRANSVAGINAL</p> <p><input type="checkbox"/> TRANSABDOMINAL</p> <p><input type="checkbox"/> OB 1ST TRIMESTER</p> <p><input type="checkbox"/> OB 14 WEEKS OR GREATER</p> <p><input type="checkbox"/> OB FOLLOW-UP</p> <p><input type="checkbox"/> OB TRANSVAGINAL</p> <p><input type="checkbox"/> BIOPHYSICAL PROFILE</p> <p><input type="checkbox"/> THYROID / NECK</p> <p><input type="checkbox"/> TESTICULAR</p> <p><input type="checkbox"/> AORTA</p> <p><input type="checkbox"/> RENAL</p> <p><input type="checkbox"/> BLADDER</p> <p><input type="checkbox"/> HYSTEROSONOGRAM</p> <p><input type="checkbox"/> EXTREMITY NON-VASCULAR BODY PART _____</p> <p><input type="checkbox"/> OTHER _____</p> <p>WOMEN'S IMAGING</p> <p>MAMMOGRAPHY</p> <p><input type="checkbox"/> MAMMO SCREEN</p> <p><input type="checkbox"/> MAMMO DIAG <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> STEREO BIOPSY <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> NEEDLE LOC <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> GALACTOGRAM <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> BONE MINERAL DENSITY</p> <p><input type="checkbox"/> OTHER _____</p> <p>ULTRASOUND</p> <p><input type="checkbox"/> BREAST</p> <p><input type="checkbox"/> CYST ASPIRATION <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> NEEDLE BIOPSY <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> OTHER _____</p> <p>NUC MED</p> <p><input type="checkbox"/> SENTINEL NODE <input type="checkbox"/> R <input type="checkbox"/> L</p>
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YOUR PATIENT'S EXAM IS SCHEDULED FOR: DATE _____ TIME _____



The Imaging Center is located at 2929 Napoleon Avenue, on the corner of South Claiborne and Napoleon Avenue.

**ARRIVE 15 MINUTES BEFORE SCHEDULED EXAM IN ORDER TO COMPLETE REGISTRATION.
 PLEASE BRING PHOTO ID AND INSURANCE INFORMATION.
 IF THERE ARE ANY QUESTIONS, PLEASE CALL 504-897-8600.**

EXAM PREPS

XRAYS

- UGI, SMALL BOWEL** NOTHING TO EAT OR DRINK AFTER MIDNIGHT.
- BE** PICK UP A BOWEL EVACUANT KIT FROM THE IMAGING CENTER AND FOLLOW THE INSTRUCTIONS.
- IVP** AT 3:00 PM ON THE AFTERNOON PRIOR TO THE EXAM, TAKE 2 OZ. OF MILK OF MAGNESIA. PATIENT MAY HAVE A CLEAR LIQUID DIET FOR SUPPER. NOTHING TO EAT OR DRINK AFTER MIDNIGHT.

CT EXAMS

- IV CONTRAST** NOTHING TO EAT OR DRINK AFTER MIDNIGHT. IF EXAM IS SCHEDULED FOR THE AFTERNOON, PATIENT MAY EAT A LIGHT MEAL UP TO FOUR (4) HOURS PRIOR TO EXAM.
- ORAL CONTRAST** NOTHING TO EAT OR DRINK AFTER MIDNIGHT. IF EXAM IS SCHEDULED FOR THE AFTERNOON, PATIENT MAY EAT A LIGHT MEAL UP TO FOUR (4) HOURS PRIOR TO EXAM.

 PICK UP TWO (2) BOTTLES OF CONTRAST AT THE IMAGING CENTER. IF A.M. APPOINTMENT, DRINK ONE (1) BOTTLE THE NIGHT BEFORE AND ONE (1) BOTTLE THE MORNING OF THE EXAM. IF P.M. APPOINTMENT, DRINK ONE (1) BOTTLE AT 6:00 AM AND ONE (1) BOTTLE ONE (1) HOUR BEFORE EXAM.

 IF YOU DO NOT PICK UP THE CONTRAST BEFOREHAND, PLEASE BE AT THE IMAGING CENTER TWO (2) HOURS BEFORE THE SCHEDULED EXAM. THIS WILL ALLOW THE CONTRAST TO BE DISTRIBUTED THROUGHOUT YOUR SYSTEM FOR A BETTER STUDY.

ULTRASOUND EXAMS

- ABDOMEN, LIMITED ABDOMEN** NOTHING TO EAT OR DRINK AFTER MIDNIGHT. IF EXAM IS SCHEDULED IN THE AFTERNOON, PATIENT MAY EAT A LIGHT MEAL UP TO SIX (6) HOURS PRIOR TO EXAM.
- PELVIC, OB, BLADDER** DRINK 32 OZ. OF WATER ONE (1) HOUR BEFORE THE EXAM AND DO **NOT** URINATE.

MRI EXAMS

- MRCP** NOTHING TO EAT OR DRINK FOUR (4) HOURS PRIOR TO EXAM.
- ALL OTHER MRI EXAMS** DO **NOT** REQUIRE A PREP.

WOMEN IMAGING

- MAMMOGRAM** DO **NOT** WEAR DEODORANT, TALCUM POWDER OR BODY LOTIONS. WEAR TWO PIECE CLOTHING.

PET/CT EXAMS

- PET/CT** PLEASE PHONE 504-897-8600 FOR SPECIAL INSTRUCTIONS.