

TODAY'S DATE: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Clinical History/Reason for Exam: \_\_\_\_\_

Insurance Information: \_\_\_\_\_ Patient's Phone: \_\_\_\_\_

Referring Physician (Print): \_\_\_\_\_ Physician Signature: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

- |  |  |
|--|--|
| <input type="checkbox"/> Radiologist may ammend order to suit protocol (SOP) | <input type="checkbox"/> Patient to bring images to Doctor       |
| <input type="checkbox"/> <b>Call in STAT results</b>                         | <input type="checkbox"/> Report Only <input type="checkbox"/> CD |
| <b>Direct Phone #</b> _____  | <input type="checkbox"/> CC Report to (primary care): _____      |

### MR (High-Field)

#### MRI

- Contrast at Rad's Discretion
- With & Without Contrast
- Without Contrast
- Brain:
  - \_\_\_ IAC w/wo \_\_\_ Pituitary w/wo
  - NeuroQuant (Volumetric Study):
    - \_\_\_ Alzheimer's/Dementia
    - \_\_\_ Seizure \_\_\_ Pediatric
    - \_\_\_ General (MS, Trauma)
- Orbits w/wo
- Neck (Soft Tissue) w/wo
- Spine:
  - \_\_\_ Cervical \_\_\_ Thoracic \_\_\_ Lumbar
- Extremity: Joint \_\_\_ Left \_\_\_ Right  
Specify Body Part: \_\_\_\_\_
- Extremity: Non-Joint \_\_\_ Left \_\_\_ Right  
Specify Body Part: \_\_\_\_\_
- Brachial Plexus
- Abdomen:
  - \_\_\_ Liver w/wo \_\_\_ Pancreas w/wo
  - \_\_\_ Kidneys w/wo \_\_\_ Adrenals
  - \_\_\_ MRCP
- Pelvis w/wo
  - \_\_\_ Bony Pelvis \_\_\_ Soft Tissue w/wo
- Other: \_\_\_\_\_

#### MR Angiography (includes veins)

- Contrast at Rad's Discretion
- With & Without Contrast
- Without Contrast
- Brain w/o
- Head MRV w/o
- Neck (Carotids) w/wo
- Thoracic Aorta w/wo
- Abdominal Aorta w/wo
- Abdomen

#### MR Arthrography \_\_\_ Left \_\_\_ Right

- Shoulder  Hip  Wrist
- Knee  Elbow  Ankle

### CT

#### Diagnostic CT

- Contrast at Rad's Discretion
- With & Without Contrast
- With Contrast
- Without Contrast
- Brain
- Orbits
- Temporal Bones
- Maxillofacial (Facial Bones)
- Sinus
- Neck (Soft Tissue)
- Spine:
  - \_\_\_ Cervical \_\_\_ Thoracic \_\_\_ Lumbar
- Extremity: \_\_\_ Left \_\_\_ Right  
Specify Body Part: \_\_\_\_\_
- Chest:
  - \_\_\_ Smokers Lung Cancer Screening
  - \_\_\_ HRCT (High Resolution)
- Abdomen (Pelvis if indicated)
- Abdomen and Pelvis
- Urogram (Abdomen/Pelvis) w/wo
- Stone Study
- Pelvis
- Other: \_\_\_\_\_

#### Cardiac CT

- Cardiac Calcium Score

#### CTA (Angiography)

- Head
- Neck
- Extremity: \_\_\_ Upper \_\_\_ Lower
- Chest
  - \_\_\_ Pulmonary Embolism
- Thoracic Aorta
- Abdominal Aorta
- Abdominal Aorta + runoff
- Pelvis

Creatinine: \_\_\_\_\_  
Lab Date: \_\_\_\_\_

### X-Ray

- Head:
  - \_\_\_ Skull \_\_\_ Orbits \_\_\_ Sinuses
- Spine:
  - \_\_\_ Ltd \_\_\_ Complete
  - \_\_\_ Cervical \_\_\_ Thoracic \_\_\_ Lumbar
  - \_\_\_ Scoliosis Series \_\_\_ Flex/Ext.
- Chest: \_\_\_ PA \_\_\_ PA/LAT
- Ribs:
  - \_\_\_ Unilateral \_\_\_ Bilateral
  - \_\_\_ w/PA Chest
- Abdomen: \_\_\_ KUB \_\_\_ Two Views
- Pelvis
- Hips:
  - \_\_\_ w/AP Pelvis, Bilateral
  - \_\_\_ Unilateral \_\_\_ Left \_\_\_ Right
- Knee:
  - \_\_\_ Left \_\_\_ Right
  - \_\_\_ Bilateral
  - \_\_\_ Standing AP Bilateral Only
- Extremity:
  - \_\_\_ Ltd \_\_\_ Complete
  - \_\_\_ Left \_\_\_ Right \_\_\_ Bilateral
  - Specify Body Part: \_\_\_\_\_
- Shoulder:
  - \_\_\_ Left \_\_\_ Right
  - \_\_\_ AC Joint \_\_\_ Left \_\_\_ Right
  - \_\_\_ Clavicle \_\_\_ Left \_\_\_ Right
- Other: \_\_\_\_\_

### Fluoroscopy

- Esophagram
- UGI
- UGI w/ SBFT
- Small Bowel
- Other: \_\_\_\_\_

### Procedures

#### Injections

- Sacroiliac Joint Injection -  
Therapeutic under CT guided  
\_\_\_ Left \_\_\_ Right \_\_\_ Bilateral
- Therapeutic hip Injection under  
Fluoro guidance \_\_\_ Left \_\_\_ Right
- Other: \_\_\_\_\_

### Other

# LOCATION & PREPARATION INSTRUCTIONS

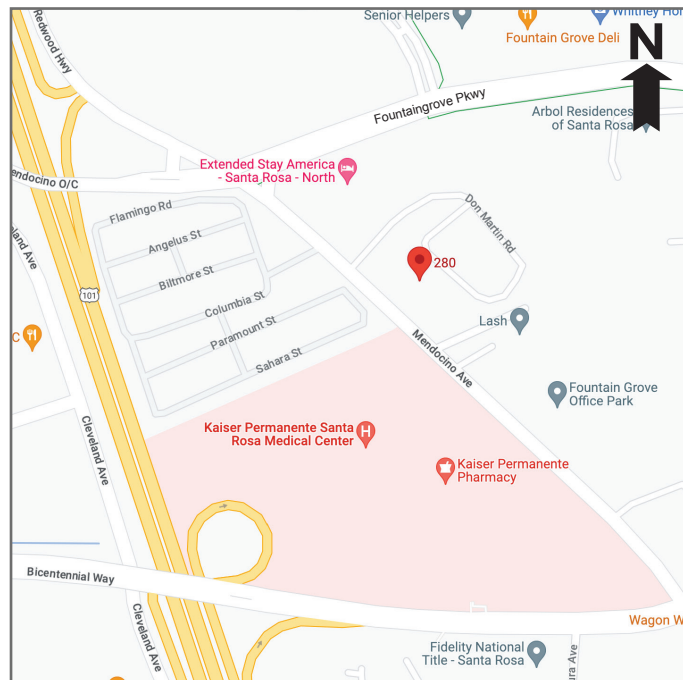
**□ MRI SCAN** Please inform us at the time of scheduling if you have any metal in your body or have had any surgeries to your eyes, ears, brain or heart. Remove any metal, jewelry or hair pins prior to your scan. Specific preparation information will be given when your appointment is scheduled. If you have any type of implant, please bring your safety card or obtain documentation that specifies the safety parameters of the implant.

**□ CT SCAN (Abdomen or Pelvis)** Please pick up the oral contrast and further instructions from our imaging center. Please inform us of any allergies to contrast, x-ray dye or iodine.

**□ G.I. and /or Small Bowel Series:** No food or drink after 10pm the evening before your exam. No chewing gum.

**AFTER THE EXAM** Your exam will be read by a board-certified, licensed physician with specialty training and certification in radiology. The results of your exam will be sent to your physician. You will receive your results from your physician.

**BILLING INFORMATION:** If you have insurance coverage, we will submit a claim to your insurance company on your behalf. If you are a member of an HMO or managed care plan, please bring your referral form and any required copayment with you at the time of your visit. You are responsible for any outstanding or unpaid balance. If you have any questions, please call our Billing Department at (844) 866-2718, option 1.



**Santa Rosa Imaging**  
A RadNet Imaging Center

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**Please call us if you have any questions regarding your procedure or preparation instructions. Study times vary in length. Please bring the following items with you to your appointment.**

**PLEASE BRING THE FOLLOWING ITEMS WITH YOU TO YOUR APPOINTMENT:**

- ✓ This Imaging Request Form
- ✓ All prior related X-Rays / Scans
- ✓ Health Insurance Card & Picture I.D.
- ✓ Pre-Authorizations you may have received

**For your safety, children may not accompany patients into procedures. If it is necessary to bring children to the appointment, please bring appropriate adult supervision to watch your children during the scan.**

**If you have asthma, please bring your inhaler to the appointment.**

**Please inform us if you may be pregnant.**