Fresno Imaging Center

Insurance Authorization #

6191 N THESTA STREET, FRESNO, CA 93710
SCHEDULING: (559)447-2600 SCHEDULING FAX: (559)447-2628

Appointment Date:_____ **Appointment Time:**_____ **Today's Date:**_____

Patient's Name:_____ **Date of Birth:**_____

Clinical History/Reason for Exam:_____

Insurance Information:_____ **Patient's Phone:**_____

Referring Physician:_____ **Physician Signature:**_____

Phone:_____ **Fax:**_____ ☐ **Patient to bring images to Doctor** ☐ **Fax STAT Report** ☐ **Call in STAT results**

CC: Physician: _____

MR

MRI

☐ **Contrast** ☐ **No Contrast**
☐ **Contrast at Rad's Discretion**
☐ **3D Rendering**
☐ Brain
- ☐ w/special attention to IAC
- ☐ w/special attention to Pituitary
- ☐ Spectroscopy

☐ Orbits
☐ TMJ
☐ Neck - Soft Tissue
☐ Spine:
___Cervical__Thoracic__Lumbar
☐ Extremity:joint __Left __Right
Specify body part_____
☐ Extremity:non-joint __Left __Right
Specify body part_____
☐ Chest
☐ Abdomen
__Adrenals __MRCP
☐ Pelvis
__Bony __Soft Tissue
☐ Enterography
☐ Other:_____

MR Angiography

☐ **Contrast** ☐ **No Contrast**
☐ **3D Rendering**
☐ Brain
☐ Neck - Carotids
☐ Chest
☐ Abdomen
__Aorta __Renal
☐ Aorta and runoff vessels
☐ Pelvis
☐ Renal Artery w/out contrast
☐ Runoff w/out contrast
☐ Other:_____

MR Arthrography **__Left __Right**
☐ Shoulder
☐ Elbow
☐ Wrist
☐ Hip
☐ Knee
☐ Ankle
☐ Other:_____

CT

Diagnostic CT

☐ **Contrast** ☐ **No Contrast**
☐ **Contrast at Rad's Discretion**
☐ **3D Rendering**
☐ Brain
☐ Orbits
☐ IAC Middle Ear
☐ Sinus (Maxillofacial)
☐ Neck (soft tissue)
☐ Spine:
__cervical __thoracic __lumbar
☐ Extremity __Left __Right
Specify body part_____
☐ Chest
☐ Abdomen (pelvis if indicated)
☐ Abdomen and Pelvis
☐ Urogram (abdomen/pelvis)
☐ Pelvis
☐ Runoff
☐ Enterography
☐ Other:_____

CTA (angiography)

☐ Head
☐ Neck
☐ Chest
☐ Abdomen
☐ Pelvis

Creatinine:_____
Lab Date:_____

Ultrasound

☐ Abdomen_____
☐ Abdomen Limited
__Liver __Gallbladder
__Right Upper Quadrant
☐ Renal
___with Bladder
☐ Bladder_____
☐ Aorta/Retroperitoneal_____
☐ Pelvis (TV if indicated)
☐ Pelvis Transabdominal Only
☐ Scrotum ___with Doppler
☐ Thyroid_____
☐ Venous Doppler (Duplex)_____
☐ Carotid Doppler (Duplex)_____
☐ Other_____

OB Ultrasound

☐ OB Ultrasound (TV if indicated)_
☐ Limited (Viability, Heart Beat, Position, Fluid, Placental Location)_____
☐ Follow-up -- specify documented problem_____
☐ Biophysical Profile_____

X-Ray

☐ Head:
__Skull __Orbits __Sinuses
☐ Spine:
__Cervical __Thoracic __Lumbar
☐ Chest: __PA ____PA/LAT
☐ Ribs:
__Unilateral__Bilateral __w/PA Chest
☐ Abdomen: __KUB __Two Views
☐ Pelvis
☐ Hips w/AP pelvis, bilateral
__Unilateral
☐ Extremity:
__Left __Right __Bilateral
Specify Body Part_____
☐ Other:_____

Fluoroscopy

☐ Arthrography
Specify body part_____
☐ IVP
☐ Esophagram
☐ Hysterosalpingogram (HSG)
☐ UGI
☐ UGI w/SBFT
☐ Small bowel
☐ Barium enema
☐ Myelogram ___C ___T ___L
___with CT ___without CT
Levels:_____

☐ Other:_____

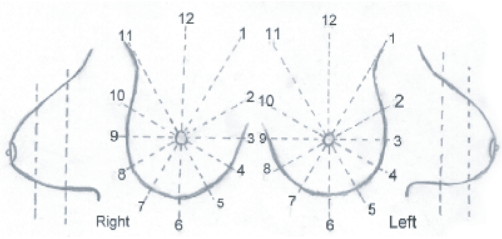
Breast Imaging

☐ Screening Mammogram
☐ Diagnostic Mammogram
__Unilateral __Bilateral
Breast Ultrasound (if indicated)
☐ Post Biopsy Mammo

☐ Breast Ultrasound
__Left __Right __Bilateral

☐ Ultrasound Guided Biopsy /Aspiration

Please mark the area of concern on the diagram.



MRI

☐ Breast- w/ contrast for mass evaluation
☐ Breast- no contrast for silicone implant

CLINICAL PROBLEM/HISTORY:

_____
_____
_____
_____
_____
_____

www.fresnoimagingcenter.com

Thank you for choosing a RadNet Center.

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