REFERRAL FORM

Appointment Date/Time

LOCATIONS

Huntington Park Advanced Imaging
A RadNet Imaging Center

☐ **Huntington Park Advanced**
2680 Saturn Ave., Suite 100
Huntington Park, CA 90255
Open MRI, CT

☐ **Huntington Park ZOE**
2679 Zoe Ave.
Huntington Park, CA 90255
P: (323) 584-3333 | F: (323) 584-3336
X-Ray, Ultrasound

Downey Advanced Imaging
A RadNet Imaging Center

☐ **Downey Radiology**
11525 Brookshire Ave., Suite 111
Downey, CA 90241
P: (562) 904-1111 | F: (562) 861-6666
MRI, CT, PET, Nuclear Medicine,
Ultrasound, Mammorgraphy, X-Ray

☐ **Montebello OPEN MRI**
1918 West Beverly Blvd.
Montebello, CA 90640
P: (323) 838-6800 | F: (323) 838-6807
Open MRI

REPORT

☐ STAT
☐ PHONE: _____
☐ FAX: _____
☐ E-Mail: _____
☐ CD TO PATIENT/ HANDCARRY
☐ CD TO DR. _____

Exams preparation instructions are on the back of the form.

This test is a medical necessity.

PATIENT

Today's Date:

Name (Last, First): _____

Phone(s): _____ Date of Birth: _____

Ordered Exam(s): _____

Diagnosis / History: _____

Referring Physician: _____

Signature: _____ Date: _____

EXAM

MR

MRI
☐ **With & Without Contrast**
☐ **Without Contrast**
☐ **Contrast as Indicated**
☐ Brain
☐ w/special attention to IAC
☐ w/special attention to Pituitary
☐ 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 Pelvis ___ Soft Tissue
☐ Other:
_____

MR Angiography (incls veins)
☐ **With & Without Contrast**
☐ **Without Contrast**
☐ **Contrast as Indicated**
☐ Brain
☐ Neck - Carotids
☐ Chest
☐ Abdomen
☐ Aorta ___Renal
☐ Pelvis
☐ Extreminty: ___Left ___Right
☐ Other:
_____

MR Arthography
☐ Shoulder
☐ Knee
☐ Other:
_____

CT

Diagnostic CT
☐ **With & Without Contrast**
☐ **Without Contrast**
☐ **Contrast as Indicated**
☐ Brain
☐ Orbits
☐ IAC Middle Ear
☐ Maxillofacial - Facial Bones
☐ Sinus (Maxillofacial)
☐ Neck - Soft Tissue
☐ Spine:
___ Cervical ___ Thoracic
___ Lumbar
☐ Extremity: Joint
___ Left ___ Right
Specify Body Part
_____
☐ Chest
☐ Abdomen (pelvis if indicated)
☐ Abdomen and Pelvis
☐ Urogram (abdomen/pelvis)
☐ Pelvis
☐ Other:
_____

CTA (angiography)
☐ Head
☐ Neck
☐ Extreminty: ___Upper ___Lower
☐ Chest
☐ Aorta and runoff vessels
☐ Abdomen
☐ Pelvis

Creatinine:
_____

Lab Date:
_____

Breast MR
☐ Contrast tumor study
☐ Implant evaluation
Date last mammogram:
_____
Breast implants: ___Yes ___No

Ultrasound

☐ Abdomen _____
☐ Abdomen Limited _____
☐ Renal w/Bladder
☐ Bladder _____
☐ Aorta/Retroperitoneal _____
☐ TV and Transabdominal
☐ Transabdominal only
☐ Transvaginal only
☐ Scrotum w/Doppler
☐ Other: _____

Vascular Studies
☐ Arterial Doppler (Duplex) ____
☐ Carotid Doppler (Duplex) ____
☐ Venous Doppler (Duplex) ____
☐ Extreminty: ___Upper ___Lower
___L ___R ___Bil
☐ Other: _____

OB Ultrasound
☐ OB Ultrasound (TV if indicated)___
☐ Limited (Viability, Heart Beat, Position, Fluid, Placental Location) _____
☐ Follow-up -- specify documented problem _____
_____

Fluoroscopy

☐ Arthrography
Specify body part:
_____
☐ VCUG
☐ Esophagram
☐ Hysterosalpingogram (HSG)
☐ UGI
☐ UGI w/SBFT
☐ Small Bowel
☐ Other:
_____

Breast Imaging

☐ Screening Mammogram
☐ Diagnostic Mammogram
Breast Ultrasound (if indicated)
___Unilateral ___Bilateral
☐ Breast Ultrasound
___ Left ___ Right ___Bilateral
Date last mammogram:
_____

Nuclear Medicine

☐ Bone:
___ Whole Body ___Limited ___3-phase
☐ Bone SPECT
☐ Thyroid Scan
☐ Thyroid Uptake and Scan
☐ Parathyroid
☐ Myocardial Perfusion (heart)
___ Exercise ___ Pharmacologic
☐ MUGA (cardiac blood pool)
☐ Lung VQ
☐ Liver/Spleen
☐ Gallbladder (HIDA) with CCK
☐ Gallbladder without CCK
☐ GI Emptying
☐ GI Bleed
☐ Meckels
☐ Renal ___Captopril ___Lasix
☐ Gallium
☐ White Blood Cell (WBC)
☐ Other:
_____

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 ___ Left ___Right
☐ Extreminty:
___ Left ___ Right ___Bilateral
Specify body part:
_____
☐ Other:
_____

DEXA

☐ Bone Dexa
Reason for bone density
_____
Date of last exam:
_____

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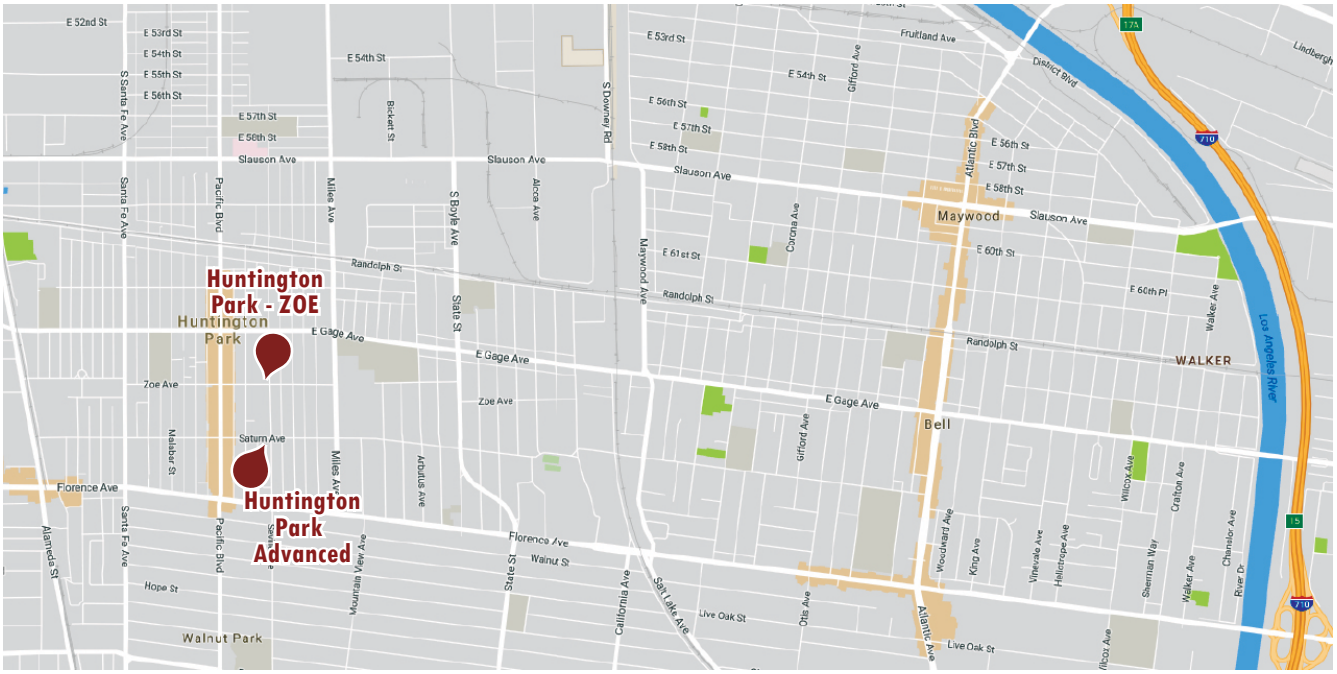

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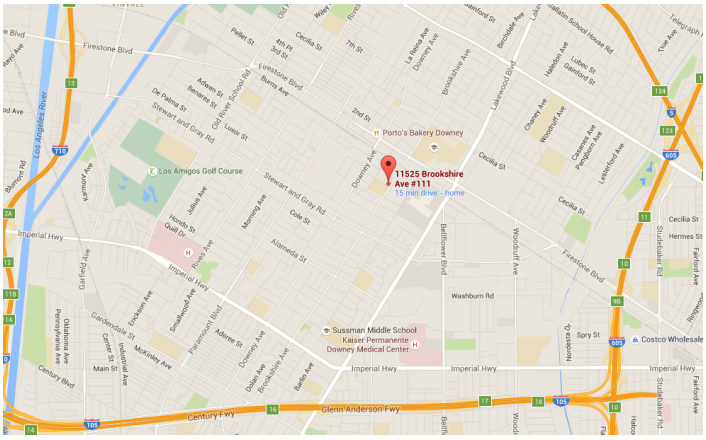

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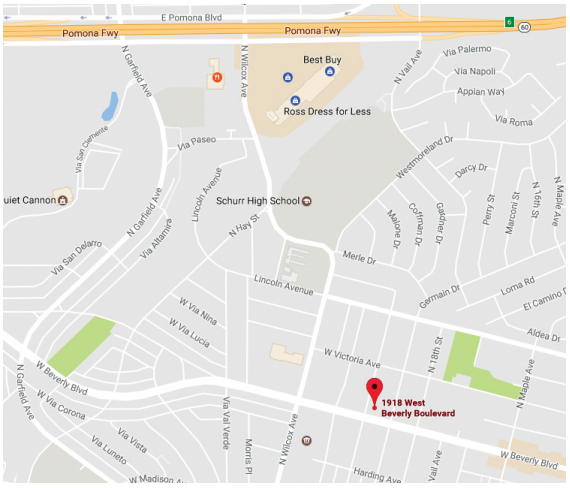

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