

APPOINTMENT INFO:

Date: _____ Time: _____

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: _____

☐ Patient to bring images to Doctor

☐ Report Only

☐ CD

☐ Call in STAT results

☐ CC Report to: _____

MR

MRI

☐ With & Without Contrast

☐ With Contrast

☐ Without Contrast

☐ 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: _____

☐ Non-Joint ___Left ___Right

Specify body part: _____

☐ Chest

☐ Abdomen

___Adrenals

___MRCP

☐ Pelvis:

___Bony Pelvis ___Soft Tissue

☐ Other: _____

MRI Angiography

☐ With & Without Contrast

☐ With Contrast

☐ Without Contrast

☐ Brain - COW

☐ Neck - Carotids

MR Venogram

☐ Brain without contrast

DIAGNOSTIC CT

Diagnostic CT

☐ With & Without Contrast

☐ With Contrast

☐ Without Contrast

☐ Brain

☐ Orbits

☐ IAC Middle Ear

☐ Maxillofacial - Facial Bones

☐ Sinus (Maxillofacial)

☐ Neck (Soft Tissue)

☐ Spine:

___Cervical ___Thoracic

___Lumbar

☐ Extremity:

___Left ___Right ___Bilateral

Specify body part: _____

☐ Chest

☐ Abdomen (pelvis if indicated)

☐ Abdomen and Pelvis

☐ Pelvis

☐ Other: _____

Creatinine: _____

Lab Date: _____

FLUOROSCOPY

☐ Arthrography

___Left ___Right

___Shoulder

___Elbow

___Wrist

___Hip

___Knee

___Ankle

☐ Other: _____

DEXA

Reason for bone density:

Date of last exam: _____

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

☐ Extremity:

___Left ___Right ___Bilateral

Specify body part: _____

☐ Other: _____

☐ Designate Views:



Please bring this Imaging Request Form, I.D. and your insurance card with you on the day of your exam.

LOCATIONS & 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.

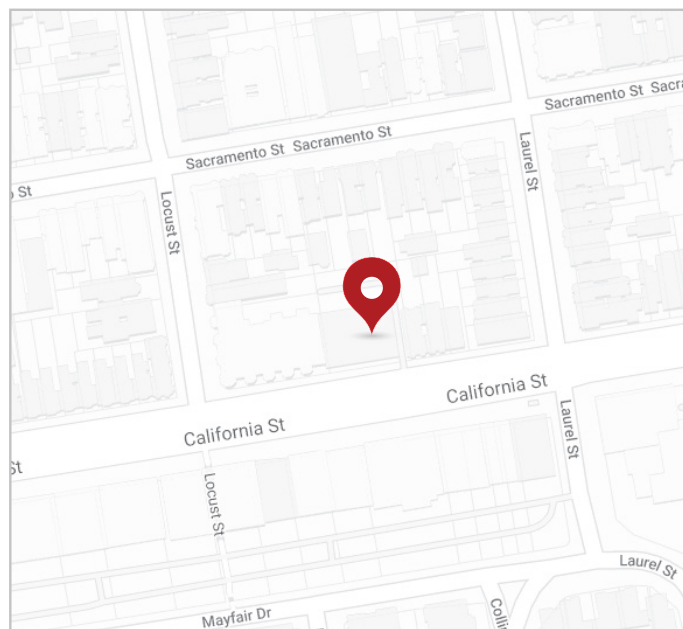
□ DEXA Do not take calcium supplements 24 hours prior to your scan. If you have any x-rays using contrast such as barium, IV contrast or any nuclear medicine studies, please wait one week before having a DEXA scan. If you have any of these tests scheduled for the same day as your DEXA scan, the DEXA must be performed first.

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.

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



RadNet Medical Imaging San Francisco

3440 California Street
San Francisco, CA 94118

Phone: (415) 922-6767

Fax: (415) 563-0468

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.