



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

Reason for Exam/ ICD10 Code: _____

Surgical/Navigational Protocol: _____

Referring Provider (Print): _____ Provider Signature: _____ Today's Date: _____

Phone: _____ Fax: _____ CC Report To: _____

☐ Call in STAT results to: _____ ☐ Release CD with Patient

Insurance Plan: _____ Member ID#: _____

MRI

- ☐ Without Contrast
- ☐ With & Without Contrast
- ☐ Brain
 - ___ IAC/Trigeminal
 - ___ Brain Anti-Amyloid/ARIA
 - ___ Pituitary ___ Spectroscopy
 - ___ Quantitative Volumetric Analysis:
 - ___ Dementia/MCI ___ Seizures
 - ___ MS ___ TBI ___ Peds
- ☐ Orbits
- ☐ TMJ
- ☐ Soft Tissue Neck
- ☐ Chest
- ☐ Breast w/wo Contrast
- ☐ Breast wo Contrast (Implant evaluation only)
- ☐ Brachial Plexus:
 - ___ Left ___ Right ___ Bilateral
- ☐ Abdomen (Liver, Kidney, Adrenals, etc)
 - ___ MRCP (Pancreas) ___ Enterography
 - ___ Eovist (liver) ___ Liver Iron Quant
 - ___ Fat Fraction ___ Elastography
- ☐ Pelvis
- ☐ Prostate w/wo Contrast
 - ___ w/ Bones and Nodes
- ☐ Enhanced Prostate Screening wo Contrast
- ☐ Other: _____
- Spine**
 - ___ Cervical ___ Thoracic
 - ___ Lumbar ___ Sacrum/Coccyx
- Joint** ___ Left ___ Right ___ Arthrogram
 - ___ Shoulder
 - ___ Elbow
 - ___ Wrist
 - ___ Hip
 - ___ Knee
 - ___ Ankle
 - ___ Other: _____
- ☐ Non-Joint Lower Extremity: _____
- ☐ Non-Joint Upper Extremity: _____

MR Angiography:

- ___ Brain
- ___ Neck
- ___ Thoracic Aorta
- ___ Thoracic Outlet
- ___ Chest
- ___ Abdomen
- ___ Abdominal w/run-off
- ___ Renal Arteries

MR Venogram:

- ___ Head
- ___ Neck

CT

Screening CT
☐ Low-Dose Lung Cancer Screening

Diagnostic CT

- ☐ Without Contrast
- ☐ With Contrast
- ☐ With & Without Contrast
- ☐ Contrast at Rad's Discretion
- ☐ 3D Reconstruction if Indicated

☐ Diabetic / Renal Issues

CT Contrast Studies Only. Creatinine value must be obtained within 60 days of exam for patients with diabetes or known renal issues.
Please fax lab results or provide lab name where performed:

- ☐ Brain ☐ Orbits ☐ IAC Middle Ear
- ☐ Maxillofacial (Facial Bones)
- ☐ Sinus (Maxillofacial)
- ☐ Neck (Soft Tissue)
- ☐ Spine: ___ Cervical ___ Thoracic ___ Lumbar
- ☐ Extremity: ___ Left ___ Right
 - Specify Body Part: _____
- ☐ Chest
- ☐ Abdomen
- ☐ Abdomen and Pelvis
- ☐ Urogram (Abdomen/Pelvis):
 - ___ Contrast if Needed
- ☐ Enterography
- ☐ Pelvis
- ☐ Other: _____

CTA (Angiography)

- ☐ Brain ☐ Chest ☐ Abdomen
- ☐ Neck ☐ Aorta ☐ Pelvis

CORONARY/CARDIAC CT

- ☐ Coronary Artery Calcium Score (75571)
- ☐ Other: _____

ULTRASOUND

- ☐ Abdomen
- ☐ Abdomen Limited:
 - ___ Liver ___ Gallbladder
 - ___ Right Upper Quadrant
- ☐ Aorta/Retroperitoneal
- ☐ Renal:
 - ___ w/Bladder
- ☐ Bladder
- ☐ Pelvic (Transabdominal and Transvaginal)
- ☐ Pelvic Complete (Transabdominal Only)
- ☐ Pelvic (Transvaginal Only)
- ☐ Scrotum: ___ w/Doppler
- ☐ Thyroid
- ☐ Other: _____

Vascular Studies

- ☐ Arterial Doppler (Duplex):
 - ___ Upper ___ Lower ___ L ___ R ___ Bil
- ☐ Carotid Doppler (Duplex)
- ☐ Renal Doppler (Duplex)
- ☐ Venous Doppler (Duplex/DVT):
 - ___ Upper ___ Lower ___ L ___ R ___ Bil
- ☐ Venous Insufficiency
 - Lower Extremities
 - ___ L ___ R ___ Bil
- ☐ Other: _____

OB Ultrasound

- ☐ OB Ultrasound less than 14 weeks (TV if Indicated)
- Problem: _____

DEXA

- ☐ Hip & Spine
- ☐ Radius/Wrist/Heel
- ☐ Hip & Spine & Radius/Wrist/Heel

X-RAY

For availability and to schedule, visit XRHours.com

- ☐ 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: _____
- Specify Values: _____

BREAST IMAGING

- ☐ 3D Screening Mammogram
 - ___ Proceed w/ Diagnostic Mammo and/or Ultrasound if Indicated
 - ___ EBCCD® Recommended
- ☐ 3D Diagnostic Mammogram (Breast Ultrasound if Indicated)
 - ___ Left ___ Right ___ Bilateral
- ☐ 3D Diagnostic Mammogram
- ☐ Screening Breast Ultrasound
- ☐ Diagnostic Breast Ultrasound
 - ___ Left ___ Right ___ Bilateral
- ☐ Ultrasound Guided Breast Biopsy

☐ **Additional breast imaging as clinically indicated:**

Checking box authorizes radiologist to proceed with, Diagnostic Mammogram, Breast Ultrasound, Breast MRI w/wo contrast and/or applicable Biopsy.

OTHER EXAMS

NPI# 1962457812

Tax ID# 95-4651287

Locations & Services

Scheduling Phone: (760) 280-0945 / Scheduling Fax: (760) 630-0015

		MRI	Open MRI	MRA	CT	PET/CT	Screening Mammo	Diagnostic Mammo	Mammography	Ultrasound	Vascular Ultrasound	Fluoroscopy	Arthrogram	X-Ray	Ultrasound Guided Breast Biopsy	DEXA
Pacific Advanced Imaging 3909 Waring Road, Suite B & C, Oceanside, CA 92056	Phone: (760) 630-0014	1.5		64												
Pacific Advanced Imaging - Fallbrook 521 E. Elder St. Suite 101, Fallbrook, CA 92028	Phone: (760) 979-1116															

1.5 = 1.5T MRI

64 = Siemens 64 Slice CT

Map & 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) Begin drinking 32oz of water 1 hour before your appointment time. Please inform us of any allergies to contrast, x-ray dye or iodine.

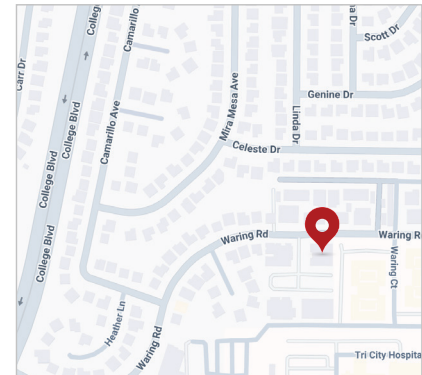
DEXA (Bone Density Scan) Prior to your appointment: Please stop taking any calcium supplements and/or any vitamins that include calcium, 2 days before. It is okay to continue to eat/drink dairy products.

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.

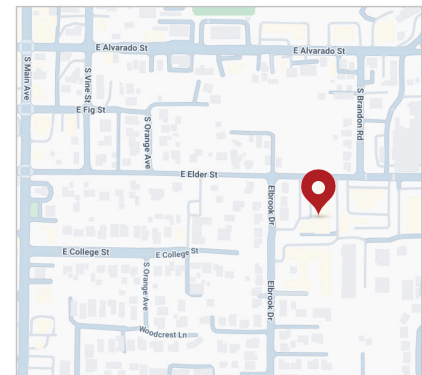
BILLING INFORMATION If you have insurance coverage, we will submit a claim to your insurance company on your behalf. If you are a member of an HMO or managed care plan, please bring your referral form and any required copayment with you at the time of your visit. You are responsible for any outstanding 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



Pacific Advanced Imaging
3909 Waring Road, Suite B & C
Oceanside, CA 92056



Pacific Advanced Imaging - Fallbrook
521 E. Elder St., Suite 101
Fallbrook, CA 92028

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.

Animals are not permitted in exam rooms. Service dogs only.