



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#: _____

MR

MRI

- ☐ Contrast at Rad's Discretion
- ☐ Without Contrast
- ☐ With & Without Contrast

Brain:

- ☐ IAC ☐ Pituitary
- ☐ Brain Anti-Amyloid/ARIA

☐ Quantitative Volumetric Analysis

- ___ Dementia/MCI ___ TBI
- ___ Seizures ___ Pediatrics
- ___ MS ___ LesionQuant

☐ Spectroscopy Brain

- ☐ Orbits
- ☐ TMJ
- ☐ Neck (Soft Tissue)
- ☐ Brachial Plexus ___L ___R
- ☐ Spine:
___Cervical___Thoracic___Lumbar
- ☐ Sacrum and Coccyx
- ☐ Extremity: ___Left ___Right
Specify Body Part: _____

☐ Chest

- ☐ Abdomen:
___Adrenals ___MRCP
___Iron Quantification
- ☐ Elastography (Liver Study)
- ☐ Enterography
- ☐ Pelvis ___Bony Pelvis ___Soft Tissue
- ☐ Prostate w/wo Contrast
___Bones and Nodes

☐ Enhanced Prostate Screening w/o Contrast

- ☐ Breast ___CAD ___Mass ___Implant
- ☐ Other: _____

MR Angiography

- ☐ Contrast at Rad's Discretion
- ☐ Without Contrast
- ☐ With & Without Contrast

- ☐ Brain
- ☐ Neck (Carotids)
- ☐ Chest
- ☐ Brachial Plexus ___L ___R
- ☐ Abdomen
___Aorta ___Renal
- ☐ Pelvis
- ☐ Other: _____

MR Arthrography ___Left ___Right

- ☐ Shoulder ☐ Hip(s) ☐ Wrist
- ☐ Knee ☐ Elbow ☐ Ankle

FLUOROSCOPY

☐ Hysterosalpingography (HSG)

- ☐ Other: _____

CT

Screening CT

- ☐ Low-Dose Lung Cancer Screening

Diagnostic CT

- ☐ 3D Reconstruction if indicated
- ☐ Without Contrast
- ☐ With Contrast
- ☐ With & Without Contrast
- ☐ Oral Contrast

- ☐ Renal Disease, Diabetic or
on Diabetic Medication

Creatinine: _____

Lab Date:

- Lab date needs to be within 60 Days of exam
- Fax lab report

- ☐ 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
- ☐ Pelvis
- ☐ Other: _____

CTA (Angiography)

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

CT Coronary/Cardiac

- ☐ Coronary CTA (75574)
___w/FFR* (75580)
___w/Plaque Analysis* (75577)
___w/Ejection Fraction
- ☐ CT Heart w/ Contrast Pre-EP/Left
Atrium (75572)
- ☐ Coronary Artery Calcium Score (75571)
- ☐ Other: _____

**Only performed when indicated in accordance with current guidelines.*

PET/CT

- ☐ FDG - Skull Base to Mid-Thigh
(CPT: 78815, A9552)
- ☐ FDG - Whole Body
(Melanoma; CPT: 78816, A9552)
- ☐ F-18 PSMA/PYL
(Prostate Cancer - Initial Staging or Biochemical
Recurrence; CPT: 78815, A9595)
- ☐ Ga 68 NetSpot (Neuroendocrine Tumor (NET) /
Carcinoid Tumor; CPT: 78815, A9587)
- ☐ 18F-FES Cerianna
(ER+ Breast Cancer; CPT: 78815, A9591)
- ☐ Amyloid - Brain (Alzheimer's disease, memory
loss, Mild Cognitive Impairment; CPT: 78814, Q9983)
- ☐ FDG - Brain (Metabolic; CPT: 78608, A9552)
- ☐ Other: _____

ULTRASOUND

- ☐ Abdomen
- ☐ Abdomen Limited:
___Liver ___Gallbladder
___Right Upper Quadrant
- ☐ Aorta/Retroperitoneal
- ☐ Renal:
___w/Bladder
- ☐ Bladder
- ☐ Hysterosonogram
- ☐ Pelvic (Transabdominal and Transvaginal)
- ☐ Pelvic Complete (Transabdominal Only)
- ☐ Pelvic (Transvaginal Only)
- ☐ Scrotum ___w/Doppler
- ☐ Thyroid
- ☐ Other: _____

Ultrasound Guided Biopsy

- ☐ Thyroid FNA
___Left ___Right ___Bilateral

Specify Values: _____

Vascular Studies

- ☐ Arterial Doppler (Duplex)
___Upper ___Lower ___L ___R ___Bil
- ☐ Carotid Doppler (Duplex)
- ☐ Renal Doppler (Duplex)
- ☐ Insufficiency/Varicose Vein Study (Duplex)
Lower Extremity: ___L ___R ___Bil
- ☐ Venous Doppler (Duplex/DVT)
___Upper ___Lower ___L ___R ___Bil
- ☐ Venous Mapping Extremities
___Upper ___Lower ___L ___R ___Bil
- ☐ Other: _____

OB Ultrasound

- ☐ OB Ultrasound (TV if indicated)
- ☐ OB Ultrasound - less than 14 weeks
- ☐ OB Ultrasound - more than 14 weeks
- ☐ Follow-up -- specify documented

Problem: _____

X-RAY

For availability and to schedule,
visit XRayHours.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: _____

DEXA | BONE DENSITY

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

Include (with any option above):

- ___Vertebral Fracture Assessment (VFA)
- ___Trabecular Bone Scan (TBS)

BREAST IMAGING

- ☐ 3D Screening Mammogram
___Proceed w/ Diagnostic Mammo
and/or Ultrasound if Indicated
☐ EB CD® Recommended
- ☐ 3D Diagnostic Mammogram
(Breast Ultrasound if Indicated)
___Left ___Right ___Bilateral
- ☐ 3D Diagnostic Mammogram
- ☐ Screening Breast Ultrasound
- ☐ Diagnostic Breast Ultrasound
___Left ___Right ___Bilateral
- ☐ Stereotactic Guided Breast Biopsy
- ☐ Ultrasound Guided Breast Biopsy
- ☐ MRI Guided Breast Biopsy
- ☐ MRI Breast w/wo Contrast
- ☐ MRI Breast wo Contrast
(Implant evaluation only)

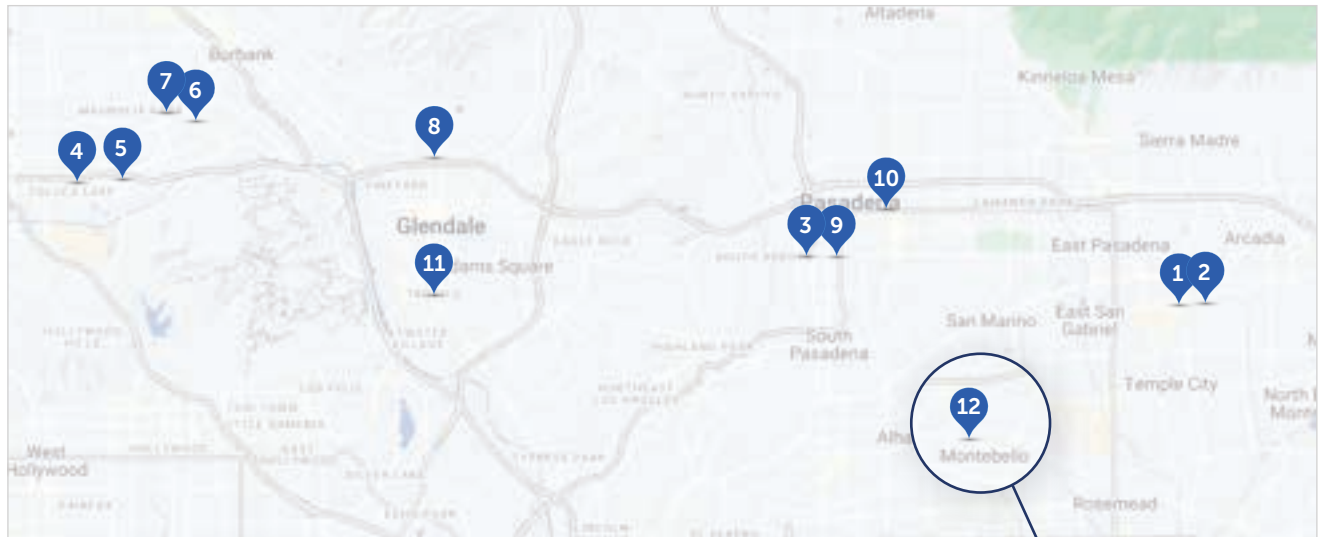
☐ Additional breast imaging as clinically indicated: Checking box authorizes radiologist to proceed with, Diagnostic Mammogram, Breast Ultrasound, Breast MRI w/wo contrast and/or applicable Biopsy.

Locations & Services

Scheduling Phone: (626) 445-4850 / Scheduling Fax: (626) 821-3460

3T = 3T MRI **1.5** = 1.5T MRI

			MRI	Open MRI	MRA	CT	PET/CT	3D Screening Mammography	3D Diagnostic Mammography	DEXA	Ultrasound	Vascular Ultrasound	Fluoroscopy	Arthrogram	X-Ray	Ultrasound Guided Breast Biopsy	Stereotactic Breast Biopsy	MRI Guided Breast Biopsy
☐	① Arcadia Radiology Imaging 612 W. Duarte Rd., Suite 101, Arcadia, CA 91007 Phone: (626) 447-0035		1.5	●	●			✗		●	●	●			●	●	●	
☐	② Arcadia Radiology Women's Imaging 622 W. Duarte Rd., Suite 104, Arcadia, CA 91007 Phone: (626) 447-0035							✗	✗		●							
☐	③ Breastlink Women's Imaging – Pasadena 630 S. Raymond Ave., Suite 201, Pasadena, CA 91105 Phone: (626) 829-8350							✗	✗	●	●					●	●	
☐	④ Burbank Advanced Imaging Center 10101 Riverside Dr., Toluca Lake, CA 91602 Phone: (818) 762-2626		1.5	●	●	●					●	●						
☐	⑤ The Burbank Breast Care Center 2601 W. Alameda Ave., Suite 101, Burbank, CA 91505 Phone: (818) 843-7462							✗	✗	●	●					●	●	
☐	⑥ Imaging Specialists of Burbank 1821 W. Olive Ave., Burbank, CA 91506 Phone: (818) 841-8880		3T	●							●	●			●			
☐	⑦ Imaging Specialists of Burbank – Pacific Ave 3413 W. Pacific Ave., Suite 101, Burbank, CA 91505 Phone: (818) 659-6044		1.5		●													
☐	⑧ Imaging Specialists of Glendale 700 N. Central Ave., Suite 100, Glendale, CA 91203 Phone: (818) 480-7234		1.5	●	●						●	●	●	●	●			
☐	⑨ Imaging Specialists of Pasadena 630 S. Raymond Ave., Suite 210, Pasadena, CA 91105 Phone: (626) 356-0700		3T	●	●	●	●				●	●						●
☐	⑩ Madison Radiology Advanced Imaging 65 N. Madison Ave., Lower Level, Pasadena, CA 91101 Phone: (626) 793-8189		1.5	●	●						●				●	●		
☐	⑪ Marcia Ray Breastlink Women's Imaging Center 222 W. Eulalia St., Glendale, CA 91204 Phone: (818) 502-2323							✗	✗	●	●					●	●	
☐	⑫ Montebello Advanced Imaging 1918 W. Beverly Blvd., Montebello, CA 90640 Phone: (323) 838-6800			●														



- Please call us if you have any questions regarding your procedure or preparation for your procedure.
- Study times vary in length. Bring ID, this form and your insurance card with you on the day of your exam.

CONNECT
PATIENT PORTAL

Take advantage of our patient portal to schedule your exam, then view your report after your appointment.
CONNECT.RadNet.com/SGVPP

