San Jacinto Imaging Center

Please arrive 30 minutes prior to your appointment for check-in

To Schedule Appointments:
Tel: (951) 587-8956
Fax: (951) 693-9173

Beverly Radiology Medical Group:
Tax ID #95-4651287

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

Patient's Name:_____ **Date of Birth:**_____ **M** or **F** (circle one)

Patient's Phone:_____ **Alternate/ Cell Phone:**_____

Clinical History/Reason for Exam:_____

_____

_____

_____

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

Phone:_____ **Fax:**_____ ☐ **Patient to bring images to Doctor** ☐ **Wet Read**

Labs needed for Contrast Studies if any of the below are marked: Creatinine _____ Lab date (within 1 month): _____
☐ Diabetes ☐ Renal Disease

MRI

MRI
- ☐ w/o contrast
- ☐ w/ and w/o contrast
- ☐ Brain
- ☐ Orbits
- ☐ IAC's
- ☐ Sella (Pituitary)
- ☐ Neck
- ☐ Shoulder ☐ L ☐ R
- ☐ Chest
- ☐ Abdomen
- ☐ Pelvis
- ☐ Hip ☐ L ☐ R
- ☐ Knee ☐ L ☐ R
- ☐ Wrist ☐ L ☐ R
- ☐ Hand ☐ L ☐ R
- ☐ C-Spine
- ☐ T-Spine
- ☐ L-Spine
- ☐ Ankle ☐ L ☐ R
- ☐ Foot ☐ L ☐ R
- ☐ Other

MRA
- ☐ w/o contrast
- ☐ w/ and w/o contrast
- ☐ Carotids/Neck
- ☐ Brain
- ☐ Renals
- ☐ Other _____

_____

_____

CT

Diagnostic CT
- ☐ with contrast
- ☐ w/o contrast
- ☐ w/ and w/o contrast
- ☐ Head
- ☐ Orbits
- ☐ Sinuses
- ☐ Temporal Bone
- ☐ Facial Bone
- ☐ Neck
- ☐ Chest
- ☐ Abdomen
- ☐ Pelvis
- ☐ C-Spine
- ☐ T-Spine
- ☐ L-Spine
- ☐ Upper Extremity ☐ L ☐ R
- ☐ Lower Extremity ☐ L ☐ R
- ☐ Urogram
- ☐ Other _____

_____

_____

CTA Angiography
(including 3D reconstruction)
- ☐ Carotids
- ☐ Chest
- ☐ Pelvis
- ☐ Abdomen
- ☐ Leg Runoff ☐ L ☐ R

Ultrasound

Ultrasound
- ☐ Abdomen, Complete
- ☐ Renal
- ☐ Aorta (Abdominal)
- ☐ OB, Complete
- ☐ OB, Limited
- ☐ Pelvis / Transvaginal
- ☐ Bladder Only
- ☐ Thyroid
- ☐ Breast ☐ L ☐ R
- ☐ Arterial Doppler (_____) ☐ L ☐ R
- ☐ Venous Doppler (_____) ☐ L ☐ R
- ☐ Carotid Doppler
- ☐ Other _____

_____

_____

Scheduling Hours:

Monday - Friday:
8am - 5pm

For Directions and site information see back of this form*

Mammography

Mammography
- ☐ Screening
- ☐ Implant Screening
- ☐ Diagnostic ☐ L ☐ R

Bone Densitometry

Bone Densitometry
- ☐ DEXA Scan
- ☐ Other _____

_____

_____

X-Ray

Specify Views_____

_____

_____

- ☐ Head:
  __Skull __Orbits __Sinuses
- ☐ Spine:
  __Cervical __Thoracic __Lumbar
- ☐ Sacrum and Coccyx
- ☐ Chest: __PA ____PA/LAT
- ☐ Ribs:
  __Unilateral__Bilateral __w/PA Chest
- ☐ Abdomen: __KUB __Two Views
- ☐ Pelvis
- ☐ Hips w/AP pelvis, bil
  __Unilateral __ L ___ R
- ☐ Extremity:
  __Left __Right __Bilateral

Specify Body Part_____

- ☐ Other:_____

_____

No Children Without Adult Supervision

www.RadNet.com

Thank you for choosing a RadNet Center.