IMAGING CENTER OF COLUMBUS

REFERRAL / SCHEDULE BY FAX FORM

Scheduling: (F) 662-328-1554 • (P) 662-328-8402

Patient Name _____ Tel: _____ Date: _____

Patient Insurance _____ Policy # _____ Group # _____ D.O.B. _____

Workers Comp _____ Atty _____ Authorization # _____

Diagnosis – Written and/or ICD-10 Code (Required) _____

Physician's Signature (Required) _____ Physician Name (please print) _____

Call Preliminary Reading Tel # _____ After Hours Tel # _____

Address _____ Tel: _____ Fax: _____

MRI

	w/o	w	w & w/o
☐ Brain	☐	☐	☐
☐ IAC	☐	☐	☐
☐ Pituitary	☐	☐	☐
☐ Orbit	☐	☐	☐
☐ Cervical Spine	☐	☐	☐
☐ Thoracic Spine	☐	☐	☐
☐ Lumbar Spine	☐	☐	☐
☐ Lower Extremity	☐	☐	☐

Body Part _____

☐ Upper Extremity	☐	☐	☐

Body Part _____

☐ Arthrogram	☐	☐	☐

Body Part _____

☐ MRCP	☐	☐	☐
☐ Other	☐	☐	☐

_____

☐ MRA	☐	☐	☐

Specify _____

X-Ray

- ☐ Chest PA/LAT
- ☐ Sinus
- ☐ Ribs - Unilateral
- ☐ Cervical Spine w/obliques
- ☐ Thoracic Spine PA/LAT
- ☐ Lumbar Spine
- ☐ Abdomen Flat & Erect
- ☐ Other

Specify _____

☐ Fluoroscopy

Specify _____

CT

	w/o	w	w & w/o
☐ Head/Brain	☐	☐	☐
☐ Soft Tissue Neck	☐	☐	☐
☐ Chest	☐	☐	☐
☐ Abdomen	☐	☐	☐
☐ Pelvis	☐	☐	☐
☐ Temporal Bone	☐	☐	☐
☐ Sinus Complete	☐	☐	☐
☐ Extremity	☐	☐	☐

Body Part _____

☐ Soft T-Neck	☐	☐	☐
☐ Cervical Spine	☐	☐	☐
☐ Thoracic Spine	☐	☐	☐
☐ Lumbar Spine	☐	☐	☐
☐ Orbits	☐	☐	☐
☐ Facial Bones w/3D recon	☐	☐	☐
☐ Other	☐	☐	☐

_____

- ☐ Coronary Calcium Scoring
- ☐ Myelogram
  - ☐ Cervical
  - ☐ Thoracic
  - ☐ Lumbar

CTA

- ☐ Coronary Artery
- ☐ Carotids
- ☐ Chest
- ☐ Abdomen
- ☐ Head
- ☐ Lower Extremities
- ☐ Upper Extremities
- ☐ Pelvis

Ultrasound

- ☐ Renal
- ☐ Renal Artery
- ☐ Gallbladder/Liver
- ☐ Abdomen Complete
- ☐ Pelvic
- ☐ Breast ☐ Right ☐ Left
- ☐ Carotid
- ☐ Echocardiogram
- ☐ Arterial Doppler ☐ w/ABI ☐ w/o ABI
  - ☐ Right ☐ Left
  - ☐ Upper ☐ Lower
- ☐ Venous Doppler ☐ Right ☐ Left
  - ☐ Upper ☐ Lower
- ☐ Appendix
- ☐ Groin
- ☐ Thyroid
- ☐ Scrotum
- ☐ Aorta
- ☐ OB ☐ 1st ☐ 2nd ☐ 3rd ☐ BPP
- ☐ Other

_____

Mammography

- ☐ Screening Mammography ☐ 2D ☐ 3D
- ☐ Diagnostic Mammography ☐ 3D (if needed)
  - ☐ Bilateral ☐ Left ☐ Right
  - ☐ Additional Views ☐ Left ☐ Right

_____

DEXA

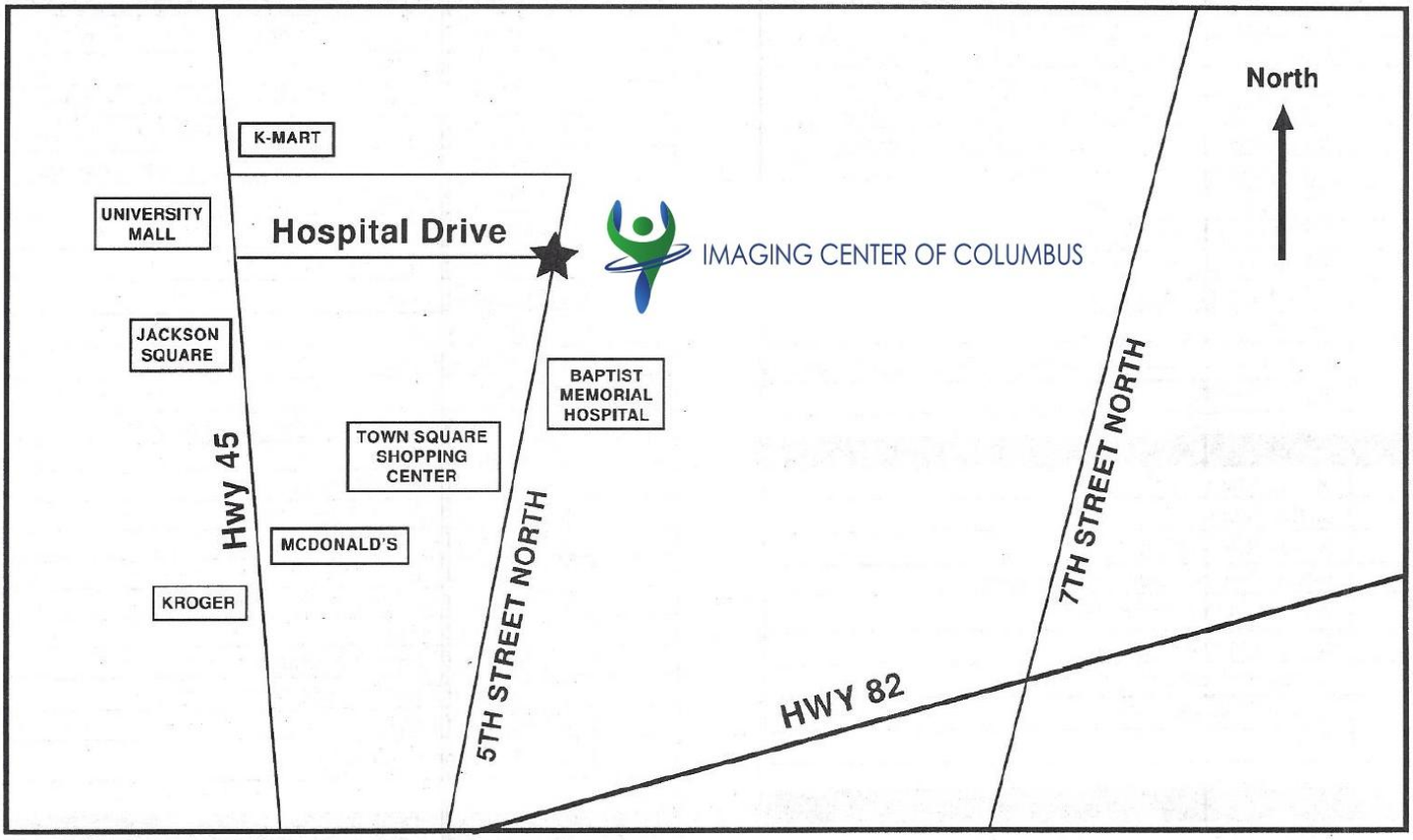
☐ DEXA Scan

Appointment Location: 2526 5th Street North • Columbus MS 39705

Appointment Date _____ **Appointment Time** _____

☐ Fax Results ☐ Call Results ☐ STAT Read ☐ Send Disk with Patient

*A 24 hour notice is required for cancellation. Cardiac pacemakers, intracranial aneurism clips and metallic foreign bodies in eyes are **not allowed in the MRI**.*



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