PARS IMAGING

REFERRAL / SCHEDULE BY FAX FORM

Scheduling: (F) 281-422-7769 • (P) 281-427-5555

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/o
Head		
☐ Brain	☐	☐
☐ IAC	☐	☐
☐ Orbit	☐	☐
☐ Pituitary Gland	☐	☐
Body		
☐ Abdomen	☐	☐
☐ GYN Pelvis	☐	☐
☐ Pelvis	☐	☐
☐ Soft Tissue Neck	☐	☐
Spine		
☐ Cervical Spine	☐	☐
☐ Thoracic Spine	☐	☐
☐ Lumbar Spine	☐	☐
Joint (shoulder/elbow/wrist/hip/knee/ankle)		
☐ Upper Ext ☐ Left ☐ Right	☐	☐
☐ Lower Ext ☐ Left ☐ Right	☐	☐
Body Part _____		
Non Joint (humerus/forearm/hand/femur/tibula/fibula)		
☐ Upper Ext ☐ Left ☐ Right	☐	☐
☐ Lower Ext ☐ Left ☐ Right	☐	☐
Body Part _____		
☐ Other_____	☐	☐

MRA

	w/o	w
☐ Circle of Willis (without only)		
☐ Carotid Artery	☐	☐

CT

	w/o	w	w & w/o
☐ Abdomen	☐	☐	☐
☐ Brain	☐	☐	☐
☐ Chest	☐	☐	☐
☐ High Resolution Chest	☐	☐	☐
☐ Upper Ext ☐ Left ☐ Right	☐	☐	☐
☐ Lower Ext ☐ Left ☐ Right	☐	☐	☐
Body Part _____			
☐ Neck	☐	☐	☐
☐ Orbits/Temporal Bone	☐	☐	☐
☐ Pelvis	☐	☐	☐
☐ Renal Stone Protocol	☐	☐	☐
☐ Sinus ☐ Limited ☐ Full	☐	☐	☐
☐ C Spine	☐	☐	☐
☐ L Spine	☐	☐	☐
☐ Sacrums/Coccyx	☐	☐	☐
☐ T Spine	☐	☐	☐
☐ Other_____	☐	☐	☐

CTA

- ☐ Aorta
- ☐ Carotid
- ☐ Chest
- ☐ Pelvis
- ☐ Renal
- ☐ Runoff Lower Ext
- ☐ Other_____

☐ Check here if your patient is to take a CD with them

☐ Deliver Disk

☐ Deliver Films

☐ STAT – Call Report

Ultrasound

- ☐ Abdominal Complete
- ☐ Abdominal Limited
- ☐ Aorta
- ☐ Carotid
- ☐ Kidney
- ☐ Kidney w/ renal artery doppler
- ☐ OB (1st tri 0-12 weeks) Transvaginal
- ☐ OB (2nd/3rd tri 13-40 weeks)
- ☐ Pelvis
- ☐ Transvaginal
- ☐ Testicular w/ Doppler
- ☐ Thyroid

Non-Inv. Venous

- ☐ Arms ☐ Left ☐ Right
- ☐ Legs ☐ Left ☐ Right

Non-Inv. Arterial (w/ABI)

- ☐ Arms ☐ Left ☐ Right
- ☐ Legs ☐ Left ☐ Right
- ☐ Other _____

X-Ray

- ☐ Facial Bones
- ☐ Orbits
- ☐ Head
- ☐ Chest PA & LAT
- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar
  - ☐ 2-3 views
  - ☐ 5 views
- ☐ Sinus
- ☐ KUB/Flat/Erect
- ☐ Ribs
- ☐ Pelvis
- ☐ Shoulder - Hip
- ☐ Extremity ☐ LT ☐ RT

Body Part _____

Special Procedure

- ☐ IVP

Patient Work Telephone: _____ Patient Cell: _____

Appointment Date _____ Time _____ Today's Date _____ Initials _____