REFERRAL / SCHEDULE BY FAX FORM

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: ______________________

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

CT

	w/o	w	w & w/o
☐ Abdomen/Pelvis	☐	☐	☐
☐ Abdomen/Pelvis (w/contrast only)			
☐ Abd/Pelv Enterography Protocol	☐	☐	☐
☐ Abdomen	☐	☐	☐
☐ Chest	☐	☐	☐
☐ Chest (w/contrast only)			
☐ Head	☐	☐	☐
☐ Pelvis	☐	☐	☐
☐ Sinus	☐	☐	☐
☐ Soft T-Neck	☐	☐	☐
☐ C Spine	☐	☐	☐
☐ T Spine	☐	☐	☐
☐ L Spine	☐	☐	☐
☐ Urogram			
☐ Lung Screen			
☐ Coronary Calcium Scoring			
☐ 3D Reconstruction			
☐ Other __________	☐	☐	☐

CTA

☐ Aorta ☐ Chest
☐ Pelvis ☐ Renal
☐ Runoff Lower Ext ☐ Carotid
☐ Other __________

Nuclear Medicine

☐ **Check here if SPECT is needed**
☐ Bone/Joint, Whole Body
☐ Bone/Joint, 3 Phase
☐ Bone/Joint, Limited
☐ SPECT Bone Area: __________
☐ DaTscan
☐ Fusion / Image Merge
☐ CT ☐ MRI
☐ Gastric Emptying
☐ HIDA w/EF
☐ I-111 Indium WBC
☐ Liver-Spleen
☐ Renal Scan
☐ Renal Scan w/ Lasix
☐ Parathyroid
☐ Thyroid w/ Uptake
☐ Other __________

MRI

	w/o	w & w/o
Head		
☐ Brain	☐	☐
☐ **Volumetric MRI**		
☐ IAC	☐	☐
☐ MS Protocol	☐	☐
Body Part(s) __________		
☐ Orbit	☐	☐
☐ Pituitary Gland	☐	☐
Body		
☐ Abdomen	☐	☐
☐ MRCP		
☐ **Abd Enterography Protocol**	☐	☐
☐ **Breast**		☐
☐ Chest	☐	☐
☐ GYN Pelvis	☐	☐
☐ Pelvis	☐	☐
☐ **Prostate with CAD**		☐
☐ Soft Tissue Neck	☐	☐
Spine		
☐ Brachial Plexus	☐	☐
☐ 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 __________		
☐ Arthrography: Body Part __________		
☐ Other __________	☐	☐

MRA

	w/o	w
☐ Aorta	☐	☐
☐ Renal	☐	☐
☐ Runoff (with only)		
☐ Circle of Willis (without only)		
☐ Carotid Artery	☐	☐

X-Ray (Please specify)

____
____
____
____

Ultrasound

☐ Abdominal Complete
☐ **Abdominal Complete w/ Liver Elastography**
☐ Abdominal Limited
☐ **Abdominal Limited w/ Liver Elastography**
☐ Aorta ☐ Carotid ☐ Hysterosonogram
☐ **Echocardiogram**
☐ 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 __________

Mammography

☐ Screening Mammography ☐ 2D ☐ 3D
☐ Diagnostic Mammography: ☐ 3D (if needed)
☐ Bilateral ☐ Left ☐ Right
☐ Additional Views ☐ Left ☐ Right
☐ Breast US ☐ Left ☐ Right (if needed)
☐ Cyst Aspiration ☐ Left ☐ Right
☐ Stereotactic Breast Biopsy ☐ Left ☐ Right
☐ US Guided Breast Biopsy ☐ Left ☐ Right

☐ w/ bilateral breast ultrasound, if needed

Bone Density

☐ AP Spine & Hip ☐ IVA
☐ Body Comp Analysis

Special Procedures

☐ Arthrogram ☐ MRI ☐ CT
Body Part __________
☐ **Hysterosalpingogram** ☐ IVP
☐ **X-Ray: Scoliosis with Stitching**
☐ Other __________

Fluoroscopy

☐ Barium Enema ☐ Esophagram ☐ GI
☐ UGISB
☐ Other __________

Appointment Location:

❑ DIS Covington (Hwy. 21)
❑ DIS Covington (Pinnacle Pkwy.)
❑ DIS Marrero (Avenue C)
❑ DIS Metairie (Houma Blvd.)
❑ DIS Metairie (Veterans Blvd.)
❑ DIS Slidell
❑ Doctors Imaging
❑ OpenSided MRI of New Orleans
❑ River Bend Imaging

Locations, Contact Numbers and Modalities Listed On Reverse

Patient Work Telephone: ______________________ Patient Cell: ______________________

Appointment Date: ______________________ Time: __________ Today's Date: __________ Initials: __________

Modality	DIS	Doctors Imaging	OpenSided MRI of New Orleans	River Bend Imaging
CT	■	■		
CTA	■	■		
Nuclear Medicine	■			
MRI	■	■	■	■
MRA	■	■	■	■
X-Ray	■	■		
Ultrasound	■	■		
Mammography	■			
Bone Density	■			
Special Procedures	■			
Fluoroscopy	■			

Diagnostic Imaging Services (six locations, please call for directions)
Southshore
(P) 504-883-5999
(F) 504-883-5364
Northshore
(P) 985-641-2390
(F) 985-641-2854

Exclusive studies performed at DIS highlighted in red

Doctors Imaging
4204 Teuton Street
Metairie LA 70006
(P) 504-883-8111
(F) 504-883-3555

Exclusive study performed at Doctors Imaging highlighted in blue

OpenSided MRI of New Orleans
One Galleria Boulevard #715
Metairie LA 70001
(P) 504-837-6736
(F) 504-837-0835

River Bend Imaging
490 Belle Terre Boulevard
Laplace LA 70068
(P) 985-359-7226
(F) 985-359-0323

**To order referral pads, please call 504-459-3213
or email referrer_updates@disnola.com with your request.**

Please include your name, practice/office name, mailing address and telephone number.