



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: _____

<input type="checkbox"/> Check here if your patient is to take a CD with them CT <input type="checkbox"/> Abdomen/Pelvis <input type="checkbox"/> w/o <input type="checkbox"/> w <input type="checkbox"/> w & w/o <input type="checkbox"/> Abdomen/Pelvis (w/contrast only) <input type="checkbox"/> Abd/Pelvis Enterography Protocol <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Abdomen <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest (w/contrast only) <input type="checkbox"/> Head <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pelvis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sinus <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Soft T-Neck <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> C Spine <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> T Spine <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> L Spine <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Urogram <input type="checkbox"/> Lung Screen <input type="checkbox"/> Coronary Calcium Scoring <input type="checkbox"/> 3D Reconstruction <input type="checkbox"/> Other _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> CTA <input type="checkbox"/> Aorta <input type="checkbox"/> Chest <input type="checkbox"/> Pelvis <input type="checkbox"/> Renal <input type="checkbox"/> Runoff Lower Ext <input type="checkbox"/> Carotid <input type="checkbox"/> Other _____ Nuclear Medicine <input type="checkbox"/> Check here if SPECT is needed <input type="checkbox"/> Bone/Joint, Whole Body <input type="checkbox"/> Bone/Joint, 3 Phase <input type="checkbox"/> Bone/Joint, Limited <input type="checkbox"/> SPECT Bone Area: _____ <input type="checkbox"/> DaTscan <input type="checkbox"/> Fusion / Image Merge <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> Gastric Emptying <input type="checkbox"/> HIDA w/EF <input type="checkbox"/> I-111 Indium WBC <input type="checkbox"/> Liver-Spleen <input type="checkbox"/> Renal Scan <input type="checkbox"/> Renal Scan w/ Lasix <input type="checkbox"/> Parathyroid <input type="checkbox"/> Thyroid w/ Uptake <input type="checkbox"/> Other _____	MRI <input type="checkbox"/> Brain w/o <input type="checkbox"/> w & w/o <input type="checkbox"/> <input type="checkbox"/> Neuroreader <input type="checkbox"/> IAC <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> MS Protocol <input type="checkbox"/> <input type="checkbox"/> Body Part(s) _____ <input type="checkbox"/> Orbit <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pituitary Gland <input type="checkbox"/> <input type="checkbox"/> Body <input type="checkbox"/> Abdomen <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> MRCP <input type="checkbox"/> Abd Enterography Protocol <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Breast <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> GYN Pelvis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pelvis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Prostate with CAD <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> <input type="checkbox"/> Spine <input type="checkbox"/> Brachial Plexus <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cervical Spine <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> <input type="checkbox"/> Joint (shoulder/elbow/wrist/hip/knee/ankle) <input type="checkbox"/> Upper Ext <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lower Ext <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> <input type="checkbox"/> Body Part _____ Non Joint (humerus/forearm/hand/femur/tibula/fibula) <input type="checkbox"/> Upper Ext <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lower Ext <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> <input type="checkbox"/> Body Part _____ <input type="checkbox"/> Arthrography: Body Part _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> <input type="checkbox"/> MRA <input type="checkbox"/> Aorta w/o <input type="checkbox"/> w <input type="checkbox"/> <input type="checkbox"/> Renal <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Runoff (with only) <input type="checkbox"/> Circle of Willis (without only) <input type="checkbox"/> Carotid Artery <input type="checkbox"/> <input type="checkbox"/> X-Ray (Please specify) _____ _____ _____	Ultrasound <input type="checkbox"/> Abdominal Complete <input type="checkbox"/> Abdominal Complete w/ Liver Elastography <input type="checkbox"/> Abdominal Limited <input type="checkbox"/> Abdominal Limited w/ Liver Elastography <input type="checkbox"/> Aorta <input type="checkbox"/> Carotid <input type="checkbox"/> Hysterosonogram <input type="checkbox"/> Echocardiogram <input type="checkbox"/> Kidney <input type="checkbox"/> Kidney w/ renal artery doppler <input type="checkbox"/> OB (1 st tri 0-12 weeks) Transvaginal <input type="checkbox"/> OB (2 nd /3 rd tri 13-40 weeks) <input type="checkbox"/> Pelvis <input type="checkbox"/> Transvaginal <input type="checkbox"/> Testicular w/ Doppler <input type="checkbox"/> Thyroid Non-Inv. Venous <input type="checkbox"/> Arms <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Legs <input type="checkbox"/> Left <input type="checkbox"/> Right Non-Inv. Arterial (w/ABI) <input type="checkbox"/> Arms <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Legs <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Other _____ Mammography <input type="checkbox"/> Screening Mammography <input type="checkbox"/> 2D <input type="checkbox"/> 3D <input type="checkbox"/> Diagnostic Mammography: <input type="checkbox"/> 3D (if needed) <input type="checkbox"/> Bilateral <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Additional Views <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Breast US <input type="checkbox"/> Left <input type="checkbox"/> Right (if needed) <input type="checkbox"/> Cyst Aspiration <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Stereotactic Breast Biopsy <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> US Guided Breast Biopsy <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> w/ bilateral breast ultrasound, if needed Bone Density <input type="checkbox"/> AP Spine & Hip <input type="checkbox"/> IVA <input type="checkbox"/> Body Comp Analysis Special Procedures <input type="checkbox"/> Arthrogram <input type="checkbox"/> MRI <input type="checkbox"/> CT Body Part _____ <input type="checkbox"/> Hysterosalpingogram <input type="checkbox"/> IVP <input type="checkbox"/> X-Ray: Scoliosis with Stitching <input type="checkbox"/> Other _____ Fluoroscopy <input type="checkbox"/> Barium Enema <input type="checkbox"/> Esophagram <input type="checkbox"/> GI <input type="checkbox"/> UGISB <input type="checkbox"/> Other _____
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- Appointment Location:**
- DIS Covington (Hwy. 21)
 - DIS Covington (Pinnacle Pkwy.)
 - DIS Marrero (Avenue C)
 - DIS Metairie (Houma Blvd.)

- DIS Metairie (Veterans Blvd.)
- DIS Slidell
- DIS Thibodaux
- Doctors Imaging
- 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	River Bend Imaging
CT	■	■	
CTA	■	■	
Nuclear Medicine	■		
MRI	■	■	■
MRA	■	■	■
X-Ray	■	■	
Ultrasound	■	■	
Mammography	■		
Bone Density	■		
Special Procedures	■		
Fluoroscopy	■		

DIS Call Center and Fax numbers for all DIS locations

Southshore Northshore
(P) 504-883-5999 - *Appointment* (P) 985-641-2390 - *Appointment*
(F) 504-883-5364 - *Fax* (F) 985-641-2854 - *Fax*

Exclusive studies performed at DIS highlighted in red

Diagnostic Imaging Services – Covington Hwy 21
71154 Highway 21
Covington LA 70433

Diagnostic Imaging Services – Metairie
3434 Houma Blvd #100
Metairie LA 70006

Diagnostic Imaging Services – Covington Pinnacle
1200 Pinnacle Pkwy #5
Covington LA 70433
***High Field Open**

Diagnostic Imaging Services – Metairie Veterans
4241 Veterans Memorial Blvd #100
Metairie LA 70006

Diagnostic Imaging Services – Marrero
925 Avenue C
Marrero LA 70072

Diagnostic Imaging Services – Slidell
1310 Gause Blvd
Slidell, LA 70458

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

Exclusive study performed at Doctors Imaging highlighted in blue

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

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.