DIAGNOSTIC IMAGING SERVICES | DOCTORS IMAGING | RIVER BEND IMAGING | DIAGNOSTIC IMAGING SERVICES THIBODAUX | OPEN MRI OF HAMMOND

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	☐	☐
☐ Neuroreader		
☐ 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
☐ River Bend Imaging
☐ DIS Thibodaux
☐ Open MRI of Hammond

Locations, Contact Numbers and Modalities Listed On Reverse

Patient Work Telephone:_____ Patient Cell:_____

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

(NOLA 9/22)