RADIOLOGY & IMAGING

Scheduling: 361-888-8875
Fax: 361-881-6210

REPORT URGENCY

❑ Regular Fax ❑ STAT Fax

❑ STAT Wet Reading (Phone Call) Report:
Phone #:______________________________

☐ **3226 S. Alameda St.**
361-888-6684
X-Ray hours 8am-5pm M-F

☐ **2825 Spohn South Drive**
361-991-9595
X-Ray hours 8am-5pm M-F

Date: ______________________ Clinical History/Diagnosis: ______________________

Patient: ____ DOB: ______________________

Patient Phone Number: ______________________________ Arrival Time: ______________________

Appointment Date/Time: ______________________ Alternate Phone Number: ______________________

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Please note: IV Contrast will be used at the discretion of the radiologist unless otherwise indicated below.

Exam #1

❑ MRI ❑ MRA ❑ CT ❑ CTA ❑ X-ray ❑ Fluoroscopy ❑ Ultrasound/Doppler ❑ Nuclear Medicine ❑ PET/CT

❑ Per Protocol ❑ BUN/Creatinine (Lab work required for patients having IV Contrast unless on dialysis) Diabetic: ❑ yes ❑ no

Biopsy of: ____

Body Part: ______________________________ Lt / Rt / Bil ICD10: ______________________

Exam reason: ____

Exam #2

❑ MRI ❑ MRA ❑ CT ❑ CTA ❑ X-ray ❑ Fluoroscopy ❑ Ultrasound/Doppler ❑ Nuclear Medicine ❑ PET/CT

❑ Per Protocol ❑ BUN/Creatinine (Lab work required for patients having IV Contrast unless on dialysis) Diabetic: ❑ yes ❑ no

Biopsy of: ____

Body Part: ______________________________ Lt / Rt / Bil ICD10: ______________________

Exam reason: ____

Exam #3

❑ MRI ❑ MRA ❑ CT ❑ CTA ❑ X-ray ❑ Fluoroscopy ❑ Ultrasound/Doppler ❑ Nuclear Medicine ❑ PET/CT

❑ Per Protocol ❑ BUN/Creatinine (Lab work required for patients having IV Contrast unless on dialysis) Diabetic: ❑ yes ❑ no

Biopsy of: ____

Body Part: ______________________________ Lt / Rt / Bil ICD10: ______________________

Exam reason: ____

Mammo/Dexa/Biopsy

❑ Screening Mammogram ❑ Bone Density (DXA) ❑ Stereotactic Breast Biopsy ❑ Genetic Testing ❑ Ultrasound Biopsy

❑ Diagnostic Breast Evaluation with Imaging as Needed (Diagnostic Mammogram and/or Breast US as indicated by patient/age/findings).

Exam reason: ____

If more than one (1) location, please include practice address: ______________________________

*Office Phone Number: ______________________ Office Fax Number: ______________________

*Referring Physician Name (Please Print): ______________________________

*Referring Physician Signature: ______________________________

CC to Other Physician: ______________________________

Patient must present Photo ID & Insurance card at time of service.
Payment is due at time of service. Any necessary payment arrangements must be made prior to the appointment.

TAX I.D. #88-1897719 NPI 1194469221