OUTPATIENT IMAGING

CAPITOL IMAGING SERVICES

To Schedule Appt
912-800-4674
Fax order, notes, demographics, and front/back of insurance card to 912-225-1775
capitolimagingservices.com

Patient Name_____ Date of Birth_____

Patient Phone_____ Insurance_____

Referring Physician_____ Physician Signature_____ Date:_____

Reason for Exam_____ **STAT** ☐ Number to call _____

Diag. Code_____

Appointment Date_____ at_____ (a.m.) (p.m.)

PLEASE BRING YOUR INSURANCE CARD. CO-PAYMENT IS EXPECTED AT THE TIME OF SERVICE.
PLEASE NOTIFY TECHNOLOGIST IF YOU ARE OR SUSPECT YOU MIGHT BE PREGNANT.

CHECK EXAMINATION DESIRED

HIGH FIELD MRI

☐ **OPEN** ☐ **CLOSED**
☐ **NO CONTRAST** ☐ **WITH/WITHOUT CONTRAST**
☐ MR Brain ☐ MR Pituitary ☐ MR IAC's
☐ MR Angiography ☐ **Brain** ☐ **Neck**
☐ MR Cervical Spine
☐ MR Thoracic Spine
☐ MR Lumbar Spine
☐ MR TMJ
☐ MR Abdomen LIVER PANCREAS RENAL
☐ MRCP
☐ MR Pelvis
☐ MR Shoulder (R) (L)
☐ MR Elbow (R) (L)
☐ MR Wrist (R) (L)
☐ MR Hand (R) (L)
☐ MR Knee (R) (L)
☐ MR Hip (R) (L)
☐ MR Foot (R) (L)
☐ MR Ankle (R) (L)
☐ MR Arthrogram - Shoulder - Hip___
☐ MR Enterography
☐ MR Cardiac
☐ MR OTHER_____

FLUOROSCOPY/ABDOMEN

☐ Esophagram/Barium Swallow
☐ Upper GI

CT SCAN (HELICAL)

☐ **ORAL**
☐ **NO CONTRAST** ☐ **WITH CONTRAST** ☐ **IV**
☐ CT Brain
☐ CT Angiography ☐ HEAD ☐ NECK
☐ CT Sinuses
☐ CT Cervical Spine
☐ CT Thoracic Spine
☐ CT Lumbar Spine
☐ CT Calcium Scoring-Coronary Arteries
☐ CT Soft Tissue Neck
☐ CT Chest
☐ CT Abdomen (diaphram to iliaccrest)
☐ CT Pelvis
☐ CT ABD/Pelvis
☐ CT Urogram
☐ CT ABD/Pelvis Stone Protocol
☐ CT Extrem & Reconstructions
☐ Low-Dose Lung Screen
☐ PE Chest
☐ CTA - Chest
☐ CTA - Runoff
☐ CTA Abd/Pelvis
☐ CTA Coronary
☐ CT Arthrogram
☐ CT OTHER_____

ULTRASOUND

☐ Aorta
☐ Abdomen
☐ Breast (with mammogram if needed)
☐ Carotid Doppler
☐ RUQ/Gallbladder/Pancreas/Liver
☐ Pelvic Complete-transabdominal with Doppler
☐ Pelvic & Transvaginal with Doppler
☐ Renal
☐ Testicular Scrotal with Doppler
☐ Venous Doppler, Extremity (UE, LE)
(R) (L) (Bil.)
☐ Arterial Doppler, Extremity (UE, LE)
(R) (L) (Bil.)
☐ Thyroid

☐ US OTHER_____

☐ **3D MAMMOGRAM - SCREENING**
☐ **3D MAMMOGRAM - DIAGNOSTIC with ultrasound if needed**
(R) (L) (BIL)

☐ **BONE DENSITY**
☐ **INSTANT VERTEBRAL**
☐ **ASSESSMENT-IVA**
☐ **Whole Body Composition**

GENERAL X-RAY

☐ KUB ☐ Bone Age
☐ Abdominal Series
☐ Nasal Bones
☐ Sinuses
☐ Chest PA/LAT
☐ Rib/PA Chest (R) (L)
☐ Cervical Spine
☐ Thoracic Spine
☐ Lumbar Spine
☐ Pelvis
☐ Sacrum/Coccyx
☐ Clavicle (R) (L)
☐ Shoulder (R) (L)
☐ Humerus (R) (L)
☐ Elbow (R) (L)
☐ Forearm (R) (L)
☐ Wrist (R) (L)
☐ Hand (R) (L)
☐ Hip (R) (L)
☐ Femur (R) (L)
☐ Tibia/Fibula (R) (L)
☐ Knee (R) (L)
☐ Ankle (R) (L)
☐ Foot (R) (L)
☐ Heel (R) (L)
☐ SI Joints
☐ Scoliosis Series
☐ OTHER _____

ACR AMERICAN COLLEGE OF RADIOLOGY ACCREDITED FACILITY

IF UNABLE TO KEEP APPOINTMENT, PLEASE CALL 24 HOURS IN ADVANCE.

TEST PREPARATIONS

MRI	No preparation required. For your comfort, you may wish to wear a sweat suit without metal closures.
CT SCAN CHEST/ABD/PELVIS	DO NOT EAT or DRINK for four (4) hours before exam. Water is acceptable.
MAMMOGRAPHY	Do not use poweders, deodorant or perfume on the day of your test. These products contain substances that show up on X-ray film and can cause an unsatisfactory exam. Please bring most recent mammogram if done at another facility.
Abdomen, Aorta, Gallbladder:	DO NOT EAT or DRINK anything after midnight of the evening prior to the exam.
Pelvic Sono:	You need a full bladder - do not void two (2) hours prior to appointment time. One (1) hour prior to your exam time drink four (4) large glasses of fluid (or (3) 8 oz. glasses of water.) Do not void until after exam. You may eat.
FLUOROSCOPY/ABDOMEN Upper GI, UGI & Small Bowel, Small Bowel Only:	DO NOT EAT or DRINK or SMOKE after midnight of the night before your exam.

If any questions regarding your preparations please call the office.

CANCELLATIONS PLEASE NOTIFY IMAGING CENTER 24 HOURS BEFORE TEST TO AVOID BEING CHARGED FOR INJECTION.

OPI STATESBORO
1601 FAIR RD, #100
STATESBORO, GA 30458