# Modesto Advanced IMAGING CENTER™

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Modesto, CA 95350

# PATIENT REFERRAL

PLEASE SEE REVERSE FOR PATIENT PREPARATION INSTRUCTIONS AND MAP

## PATIENT INFORMATION

PLEASE BRING ALL INSURANCE INFORMATION WITH YOU ON THE DAY OF THE EXAM.

PATIENT NAME______________________ DATE OF BIRTH__________

DATE OF EXAM__________ TIME OF EXAM__________ PATIENT'S PHONE: (    ) ________

☐ PHONE REPORT TO______________________

☐ FAX REPORT TO______________________

☐ ADDITIONAL REPORT TO______________________

☐ SEND FILMS TO______________________

CHIEF COMPLAINT/WORKING DIAGNOSIS ______________________

PRIOR STUDIES ☐ NO ☐ YES If Yes, Please Indicate: ______________________

ALLERGIES ☐ NO ☐ YES If Yes, Please Indicate: ______________________

## ROUTINE X-RAYS

☐ SKULL
☐ CHEST
☐ ABDOMEN SERIES
☐ ABDOMEN (KUB)

☐ SINUS __________
☐ EXTREMITY__________

☐ SPINE (LEVEL)__________
☐ OTHER__________

## FLUOROSCOPY

☐ ESOPHAGRAM
☐ UPPER G.I. SERIES
☐ SMALL BOWEL SERIES
☐ BARIUM ENEMA WITH AIR

☐ I.V.P.
☐ V.C.U.G.
☐ HYSTEROSALPINGOGRAM

☐ ARTHROGRAM (AREA) __________
☐ MYELOGRAM (LEVEL) __________
☐ OTHER__________

## ULTRASOUND

☐ ABDOMEN - ☐ COMPLETE ☐ LIMITED
☐ ABDOMEN (W/DOP
☐ AORTA / RETROPERITONEAL
☐ RENAL (KIDNEYS) - ☐ W/BLADDER
☐ TESTICULAR

☐ PELVIS (TV IF INDICATED)
☐ PELVIS TRANSABDOMINAL ONLY
☐ OB (TV IF INDICATED)
☐ THYROID
☐ BIOPSY __________

☐ CAROTID
☐ PERIPHERAL ☐ ARTERIAL ☐ VENOUS
☐ L ☐ R
☐ OTHER__________

## NUCLEAR MEDICINE / PET/CT (Please use PET/CT Order Form)

☐ BONE SCAN
__WHOLE BODY __ LIMITED __3 PHASE
☐ BONE SPECT
☐ LIVER/SPLEEN SCAN

☐ THYROID SCAN
__ W/O UPTAKE
☐ GALLBLADDER (HIDA)
__ W/O CCK

☐ P.E.T
☐ OTHER __________

## COMPUTED TOMOGRAPHY (C.T.) ☐ W/CONTRAST ☐ W/O CONTRAST

☐ BRAIN/HEAD
☐ ORBITS
☐ CHEST
☐ PELVIS
☐ BIOPSY __________

☐ PARANASAL SINUS
☐ POSTERIOR FOSSA/IAC
☐ ABDOMEN & PELVIS
☐ ABDOMEN (DOES NOT INCLUDE PELVIS)

☐ EXTREMITY
☐ LUMBAR SPINE (LEVEL)__________
☐ OTHER __________

## M.R.I. ☐ HIGH FIELD ☐ OPEN ☐ W/CONTRAST ☐ W/O CONTRAST

☐ PITUITARY
☐ TMJ
☐ BRAIN/HEAD
☐ POSTERIOR FOSSA/I.A.C.

☐ ABDOMEN
☐ PELVIS
☐ SPINE (LEVEL)
☐ OTHER __________

☐ SHOULDER ☐ R ☐ L
☐ HIPS
☐ KNEE ☐ R ☐ L
☐ EXTREMITY (AREA)__________

**MR ANGIOGRAM**
☐ BRAIN
☐ CAROTID (NECK)
☐ OTHER __________

## WOMEN'S IMAGING

### MAMMOGRAPHY

☐ UNILATERAL ☐ R ☐ L ☐ IMPLANTS

☐ SCREENING
☐ BREAST ULTRASOUND ☐ R ☐ L
☐ STEREOTACTIC BREAST BIOPSY
☐ ULTRASOUND BREAST BIOPSY

☐ DIAGNOSTIC (ULTRASOUND IF INDICATED)
☐ BONE DENSITOMETRY (DEXA)
☐ BREAST NEEDLE LOCALIZATION

__________
PHYSICIAN'S SIGNATURE

__________
DATE

A premier network of centers providing diagnostic radiology and imaging services.℠