

PATIENT INFORMATION

PATIENT NAME _____

M F DATE OF BIRTH _____ HOME PHONE (_____) _____ CELL PHONE (_____) _____

INSURANCE _____ ID # _____ AUTH # _____

Indication/Diagnosis _____ CHRONIC ACUTE

Specific anatomical site _____ LEFT RIGHT

If injury, cause/type and date of injury _____ For follow up fracture healing, date of fracture _____

Prior related treatment or complications _____

Pertinent personal or family history _____

REQUIRED or SEND H&P

REFERRING PHYSICIAN INFORMATION

PHYSICIAN NAME _____ PHYSICIAN SIGNATURE _____ DATE _____

PHONE # (_____) _____ FAX # (_____) _____ CC: _____

RADIOLOGIST MAY MODIFY THIS ORDER UNLESS THIS BOX IS CHECKED →

REQUESTED SERVICES: OBTAIN AUTHORIZATION STAT

ROUTINE X-RAYS

- | | |
|---|--|
| <input type="checkbox"/> CHEST PA & LATERAL (Two view) | <input type="checkbox"/> C-SPINE <input type="checkbox"/> T-SPINE <input type="checkbox"/> L-SPINE |
| <input type="checkbox"/> CHEST PA (Single view) | <input type="checkbox"/> SINUSES |
| <input type="checkbox"/> ABDOMEN (KUB) | <input type="checkbox"/> NASAL BONES |
| <input type="checkbox"/> ACUTE ABDOMEN SERIES (includes PA Chest) | <input type="checkbox"/> SKULL |
| <input type="checkbox"/> PELVIS | <input type="checkbox"/> RIB SERIES <input type="checkbox"/> R <input type="checkbox"/> L |
| <input type="checkbox"/> SACRUM/COCCYX | <input type="checkbox"/> HIP w/ AP PELVIS <input type="checkbox"/> R <input type="checkbox"/> L |
| <input type="checkbox"/> OTHER (Specify): _____ | <input type="checkbox"/> FINGER <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 |
| | <input type="checkbox"/> TOE <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 |

- | | | |
|-----------------------------------|----------------------------|----------------------------|
| <input type="checkbox"/> SHOULDER | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> ELBOW | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> WRIST | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> HAND | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> KNEE | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> FOOT | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> ANKLE | <input type="checkbox"/> R | <input type="checkbox"/> L |

ULTRASOUND

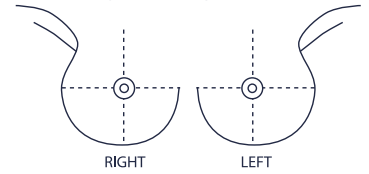
- | | |
|---|---|
| <input type="checkbox"/> ABDOMEN* | <input type="checkbox"/> TESTICULAR / SCROTUM |
| <input type="checkbox"/> AORTA* | <input type="checkbox"/> MUSCULOSKELETAL (Specify): _____ |
| <input type="checkbox"/> RENAL (KIDNEYS)* | |
| <input type="checkbox"/> THYROID | |
| <input type="checkbox"/> PELVIS w/TRANSVAG* | |
| <input type="checkbox"/> SOFT TISSUE (Specify): _____ | |
| <input type="checkbox"/> OTHER: _____ | |

VASCULAR STUDIES

- | | | | |
|---|----------------------------|----------------------------|------------------------------|
| <input type="checkbox"/> UPPER EXTR VENOUS DOPPLER | <input type="checkbox"/> R | <input type="checkbox"/> L | <input type="checkbox"/> BIL |
| <input type="checkbox"/> LOWER EXTR VENOUS DOPPLER | <input type="checkbox"/> R | <input type="checkbox"/> L | <input type="checkbox"/> BIL |
| <input type="checkbox"/> VENOUS REFLUX – Bilateral | | | |
| <input type="checkbox"/> LOWER EXTREMITY ARTERIAL DOPPLER – Bilateral | | | |
| <input type="checkbox"/> CAROTID – Bilateral | | | |
| <input type="checkbox"/> OTHER _____ | | | |

BREAST IMAGING

INDICATE LUMPS OR PALPABLE ABNORMALITIES WITH AN "X"



- | | | | |
|---|----------------------------|----------------------------|------------------------------|
| <input type="checkbox"/> SCREENING MAMMO (Asymptomatic) | <input type="checkbox"/> R | <input type="checkbox"/> L | <input type="checkbox"/> BIL |
| <input type="checkbox"/> DIAGNOSTIC MAMMO (Symptomatic) | <input type="checkbox"/> R | <input type="checkbox"/> L | <input type="checkbox"/> BIL |

Breast US will be performed if medically necessary

- | | | | |
|---|----------------------------|----------------------------|------------------------------|
| <input type="checkbox"/> BREAST US DIAGNOSTIC (Symptomatic) | <input type="checkbox"/> R | <input type="checkbox"/> L | <input type="checkbox"/> BIL |
| <input type="checkbox"/> SCREENING BREAST US (Asymptomatic) Bilateral | | | |

Diagnostic Mammo will be performed if medically necessary

- | | | | |
|---|----------------------------|----------------------------|------------------------------|
| <input type="checkbox"/> BREAST MRI W/O and W/ CONTRAST Bilateral | | | |
| <input type="checkbox"/> BREAST MRI W/O and W/ CONTRAST with IMPLANTS Bilateral | | | |
| <input type="checkbox"/> ULTRASOUND BREAST BIOPSY | <input type="checkbox"/> R | <input type="checkbox"/> L | <input type="checkbox"/> BIL |
| <input type="checkbox"/> ULTRASOUND CYST ASPIRATION | <input type="checkbox"/> R | <input type="checkbox"/> L | <input type="checkbox"/> BIL |

DEXA BONE DENSITY Escondido Office Only

- DEXA SCAN* (includes spine and hip bone mineral density plus vertebral fracture assessment)

MRI/MRA

- W/O CONTRAST W/O and W/ CONTRAST CONTRAST AT RADIOLOGIST'S DISCRETION TREATMENT PLANNING

MRI:

- | | | | | |
|--|---|---|----------------------------|---|
| <input type="checkbox"/> BRAIN | <input type="checkbox"/> BRAIN (w/ 3D volumetric post-processing for memory loss) | <input type="checkbox"/> PELVIS | | |
| <input type="checkbox"/> SELLA | | <input type="checkbox"/> SPINE <input type="checkbox"/> C <input type="checkbox"/> T <input type="checkbox"/> L | | |
| <input type="checkbox"/> IACS | | <input type="checkbox"/> SACRUM | | |
| <input type="checkbox"/> ORBITS | | <input type="checkbox"/> SHOULDER | <input type="checkbox"/> R | <input type="checkbox"/> L <input type="checkbox"/> w/ARTHROGRAM* |
| <input type="checkbox"/> TMJ | | <input type="checkbox"/> ELBOW | <input type="checkbox"/> R | <input type="checkbox"/> L <input type="checkbox"/> w/ARTHROGRAM* |
| <input type="checkbox"/> SOFT TISSUE NECK | | <input type="checkbox"/> WRIST | <input type="checkbox"/> R | <input type="checkbox"/> L <input type="checkbox"/> w/ARTHROGRAM* |
| <input type="checkbox"/> BRACHIAL PLEXUS <input type="checkbox"/> R <input type="checkbox"/> L | | <input type="checkbox"/> HIP | <input type="checkbox"/> R | <input type="checkbox"/> L <input type="checkbox"/> w/ARTHROGRAM* |
| <input type="checkbox"/> ABDOMEN* | | <input type="checkbox"/> KNEE | <input type="checkbox"/> R | <input type="checkbox"/> L <input type="checkbox"/> w/ARTHROGRAM* |
| <input type="checkbox"/> MRCP* | | <input type="checkbox"/> ANKLE | <input type="checkbox"/> R | <input type="checkbox"/> L <input type="checkbox"/> w/ARTHROGRAM* |
| <input type="checkbox"/> LIVER | | <input type="checkbox"/> FOOT | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> RENAL | | <input type="checkbox"/> OTHER: _____ | | |

MR ANGIOGRAPHY (MRA):

- | | | |
|--|--|---|
| <input type="checkbox"/> HEAD MRA | <input type="checkbox"/> CHEST MRA (Aorta) | <input type="checkbox"/> RENAL MRA |
| <input type="checkbox"/> NECK MRA (Carotids) | <input type="checkbox"/> ABDOMEN MRA (Aorta) | <input type="checkbox"/> MESENTERIC MRA |

CT/CTA

- W/O CONTRAST WITH CONTRAST* CONTRAST AT RADIOLOGIST'S DISCRETION TREATMENT PLANNING

CT:

- | | | |
|---|--|--|
| <input type="checkbox"/> HEAD | <input type="checkbox"/> ABDOMEN & PELVIS* | <input type="checkbox"/> SPINE (w/ 3D reformating) |
| <input type="checkbox"/> TEMPORAL BONES | <input type="checkbox"/> CT KUB (Renal Stone Protocol)* | <input type="checkbox"/> C <input type="checkbox"/> T <input type="checkbox"/> L |
| <input type="checkbox"/> SINUS | <input type="checkbox"/> CT UROGRAM (w/ 3D reformating)* | <input type="checkbox"/> BONE/JOINT (w/ 3D reformating) |
| <input type="checkbox"/> ORBITS (w/ 3D reformating) | <input type="checkbox"/> CT ENTEROGRAPHY* | Specify: _____ |
| <input type="checkbox"/> SOFT TISSUE NECK | <input type="checkbox"/> ABDOMEN* | |
| <input type="checkbox"/> CHEST | <input type="checkbox"/> LIVER MULTIPHASE* | |
| <input type="checkbox"/> HIGH RESOLUTION CHEST (Interstitial Disease) | <input type="checkbox"/> RENAL MASS PROTOCOL* | |
| <input type="checkbox"/> OTHER: _____ | <input type="checkbox"/> PELVIS* | |

CT ANGIOGRAPHY (CTA):*

- | | | |
|--|--------------------------------------|--|
| <input type="checkbox"/> BRAIN CTA | <input type="checkbox"/> ABDOMEN CTA | <input type="checkbox"/> ABDOMEN PELVIS CTA |
| <input type="checkbox"/> NECK CTA (Carotids) | <input type="checkbox"/> RENAL | <input type="checkbox"/> W/ LOWER EXTREMITY RUNOFF |
| <input type="checkbox"/> THORACIC ARCH CTA | <input type="checkbox"/> MESENTERIC | |
| <input type="checkbox"/> PULMONARY CTA | | <input type="checkbox"/> CT coronary Calcium Score |

LABS FOR IV CONTRAST STUDIES: pts 60yrs+
(If labs are more than six months old, obtain new labs)

Creat. = _____ GFR = _____

Date Drawn: _____

GENERAL INSTRUCTIONS

Please notify our office prior to your appointment at (760) 630-0014 (Oceanside) or (760) 743-3873 (Escondido) if:

- You **MIGHT** be pregnant.
 - You **ARE** or **MIGHT BE** allergic to CONTRAST material (including allergies to iodine or certain medications).
- If possible, please wear comfortable 2-piece clothing without metal snaps, zippers or buttons, as metal objects affect the images.

ULTRASOUND

ABDOMEN and AORTA: Nothing to eat or drink 6 hours prior to exam.

PELVIS: You should be done drinking 32 oz. of water 1 hour prior to examination. Your bladder must be full to perform the exam. Please **DO NOT** urinate prior to the exam.

RENAL: You should be done drinking 16 oz. of water 1 hour prior to examination. Please **DO NOT** urinate.

MAMMOGRAPHY

Please do not wear deodorant, powder or perfume on breast or underarm area on day of exam.

DEXA

NO calcium supplements two days prior to exam. It is suggested that you wear comfortable clothing without metal. DEXA studies cannot be scheduled within 7 days following any imaging studies that were performed with contrast, i.e. nuclear medicine, barium enema, UGI, IVP, CT, etc. Please call our office if you have any questions.

MAGNETIC RESONANCE IMAGING (MRI)

ABDOMEN and MRCP: Nothing to eat or drink for 6 hours prior to exam.

MR ARTHROGRAM

Please consult with your physician if you are taking Coumadin or other blood thinner medications.

COMPUTED TOMOGRAPHY (CT)

If you are to receive IV contrast and for all CT Angiography exams, nothing to eat 4 hours prior to your exam. Please call our offices if you are uncertain.

ABDOMEN, PELVIS: Nothing to eat for 4 hours prior to your exam. For some abdomen and pelvis CT exams you may be asked to not eat after midnight the day before your exam. You may also need to drink oral contrast; please call our offices for specific instructions.

CT ENTEROGRAPHY: Nothing to eat after midnight; please arrive one hour before your appointment.

CT UROGRAM: Nothing to eat for 4 hours prior to your appointment; please drink plenty of water.

CT CALCIUM SCORE: No caffeine for 24 hours prior to your appointment.



Maps and Directions

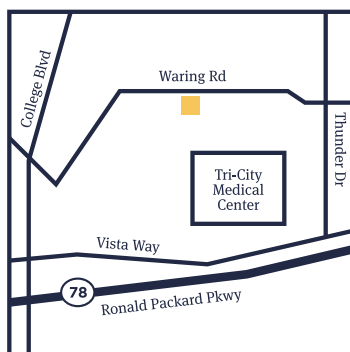
NORTH COUNTY RADIOLOGY OCEANSIDE

3909 Waring Road, Suites B & C, Oceanside, CA 92056

T 760.630.0014

F 760.630.0015

MRI, MR ARTHROGRAM, CT, DIGITAL MAMMOGRAPHY, BREAST MRI, BREAST BIOPSY, ULTRASOUND, VEIN, X-RAY



DIRECTIONS TO NORTH COUNTY RADIOLOGY OCEANSIDE

Driving East on 78

1. Exit College Blvd
2. Left at College Blvd
3. Go under freeway to Waring Road
4. Right at Waring Road

Driving West on 78

1. Exit College Blvd
2. Right at Vista Way
3. Left at Thunder Drive
4. Left at Waring Road

NORTH COUNTY RADIOLOGY ESCONDIDO

1955 Citracado Parkway, Suite 100, Escondido, CA 92029

T 760.743.3873

F 760.743.3874

MRI, MR ARTHROGRAM, CT, PET/CT, BREAST MRI, ULTRASOUND, DIGITAL MAMMOGRAPHY, DEXA BONE DENSITY, X-RAY



DIRECTIONS TO NORTH COUNTY RADIOLOGY ESCONDIDO

Driving North or South on I-15

1. Exit Valley Parkway
2. Head West on W. Valley Parkway
3. Right on S. Auto Parkway
4. Left on S. Andreasen Drive
5. Right on Citracado Parkway

Driving East on 78

1. Exit Nordahl Road
2. Right at Nordahl Road
3. Continue on Auto Parkway
4. Right on Citracado Parkway