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The Radiology Clinic

PATIENT NAME: _____ **DATE:** _____

MRI

HEAD AND NECK

- ☐ MRI BRAIN
- ☐ MRI IAC
- ☐ MRI BRACHIAL PLEXUS
- ☐ MRI PITUITARY
- ☐ MRI ORBIT
- ☐ MRI OTHER _____
- ☐ MRI TMJ
- ☐ MRI NECK (SOFT TISSUE)

SPINE

- ☐ MRI CERVICAL
- ☐ MRI THORACIC
- ☐ MRI LUMBAR

BODY

- ☐ MRI CHEST
- ☐ MRI ABDOMEN
- ☐ MRCP
- ☐ MRI PELVIS

EXTREMITY

- ☐ MR ARTHROGRAPHY
- ☐ MRI SHOULDER R / L
- ☐ MRI HIPS R / L
- ☐ MRI KNEE R / L
- ☐ MRI ANKLE R / L
- ☐ MRI FOOT R / L
- ☐ MRI WRIST R / L
- ☐ MRI HAND R / L
- ☐ MRI ELBOW R / L

MR ANGIOGRAPHY

- ☐ MRA HEAD
- ☐ MRA NECK
- ☐ MRA ABDOMEN
- ☐ MRA RENAL
- ☐ MRA CHEST
- ☐ MRA OTHER _____

CT (WITH 3D RENDERING AS NEEDED)

- ☐ CT BRAIN
- ☐ CT SINUSES/MAXILLOFACIAL
- ☐ CT ORBIT
- ☐ CT NECK (SOFT TISSUE)
- ☐ CT TEMPORAL BONE / IAC
- ☐ CT SPINE - CERVICAL / THORACIC / LUMBAR
- ☐ CT CORONARY CALCIUM SCORING
- ☐ CTA ANGIOGRAPHY _____
- ☐ BRAIN LAB
- ☐ CT CHEST
- ☐ CT ABDOMEN
- ☐ CT PELVIS
- ☐ CT ABDOMEN AND PELVIS
- ☐ CT COLONOGRAPHY
- ☐ CT ENTEROGRAPHY
- ☐ CT UROGRAM
- ☐ CT OTHER _____

INTRAVENOUS CONTRAST

- ☐ YES
- ☐ NO
- ☐ PER RADIOLOGIST

CREATININE _____ / GFR _____ / DATE DRAWN _____

ULTRASOUND

- ☐ ABDOMEN
- ☐ RENAL AND BLADDER
- ☐ THYROID
- ☐ SCROTUM
- ☐ PELVIS (TV IF INDICATED)
- ☐ OB (TV IF INDICATED)
- ☐ ABDOMINAL AORTA
- ☐ EXTREMITY ARTERIAL
- ☐ DVT R / L
- ☐ CAROTID DOPPLER
- ☐ RENAL ARTERY DOPPLER
- ☐ OTHER _____

DIGITAL XRAY

- ☐ XRAY _____

CLINICAL HISTORY / DIAGNOSIS _____

ORDERING PHYSICIAN _____ **SIGNATURE** _____

TELEPHONE _____ **FAX** _____

SPECIAL INSTRUCTIONS _____