IMAGING CENTER

Saint Agnes Imaging Center

Phone: 559-450-6742 Fax 559-450-6743

Fax this order, a copy of insurance card, and
Patient demographic information to 559-450-6743

PHYSICIAN ORDERS (Please give to patient to bring with them) Patient instruction and map on back.

Patient's Name: ______________________ DOB: __________ Phone: ____________
Insurance:
ID# ______________________
Ins. Co. ______________________

Please attach chart notes that support the need for each exam. Our office will contact the insurance company for authorization.

Comments/Allergies: ______________________

Physician's Signature: ______________________ Date: ____________
C.C. Additional Report to: ______________________

Special Exams (appointment required) *

CT

IV Contrast ☐ Yes ☐ No ☐ If indicated
☐ Head Brain
☐ Sinus
☐ Orbits
☐ Temporal bone
☐ Neck, Soft Tissue
☐ Chest
☐ CT **Abdomen & Pelvis**
☐ CT Abdomen – (covers diaphragm to Create of pelvis)
☐ CT Abdomen: **please include pelvis If warranted per radiologist**

☐ CT Pelvis – (covers crest of pelvis to Symphysis)

☐ CT Pelvis: **please include abdomen if Warranted per radiologist.**

☐ C-spine (levels) __________
☐ T-spine (levels) __________

☐ L-spine (levels) __________
☐ Upper Ext ☐ R ☐ L
Specify area __________

☐ Lower Ext ☐ R ☐ L
Specify area __________
☐ CT Angiography
☐ CT Pulmonary Angiography
☐ Other: __________
Comments: __________

CTA

☐ Head
☐ Neck
☐ Chest
☐ Extremity __________

FLURO

☐ Fluro-guided therapeutic joint inj: __________

☐ Fluro-guided joint injection for arthrogram joint: __________
☐ MRI or ☐ CT

Miscellaneous

☐ Bone Densitometry (DEXA)

MR

IV Contrast ☐ Yes ☐ No ☐ If indicated
☐ **Orbits for mental detection (pre-exam)**
☐ Head/Brain ☐ MRA – Cranial Special Instructions: __________
____

☐ Orbits ☐ Sinus ☐ TMJ ☐ IAC
☐ Neck, Soft Tissue
☐ MRA – Neck/Carotid ☐ Pituitary
☐ C -spine (levels) __________
☐ T-spine
☐ L-spine
☐ Sacrum
☐ Chest
☐ Abdomen
Specify area __________
☐ Pelvis
☐ Upper Ext ☐ RT ☐ LT
Specify area __________
☐ Lower Ext ☐ RT ☐ LT
Specify area __________
☐ MRA-other: __________
☐ Plexus Study
Specify area: __________
☐ Breast
Other: __________
Comments: __________

Ultrasounds

☐ Abdomen (Liver, GB, Panc Kidney, spleen)
☐ Kidneys
☐ APPY only
☐ Kidney & Bladder
☐ Aorta
☐ Pelvis (Uterus, Ovaries / EV)
☐ Pregnancy comp
☐ Biophysical Profile
☐ Thyroid
☐ DVT Leg, Uni ☐ RT ☐ LT
☐ DVT Arm, Uni ☐ RT ☐ LT
☐ Preg, ltd w/AFI (fluid index)
☐ Scrotum
☐ Vein Competency ☐ RT ☐ LT ☐ Bil
☐ Elastography

Routine Xray Walk-ins Welcome

Head and Neck

☐ Mandible, Comp
☐ Face Comp
☐ Nasal Bone
☐ Snus Comp
☐ Skull, Comp

Chest

☐ Chest PA
☐ Chest PA & LAT
☐ Chest 2 vws & Apical lordotic
☐ RIBS, w/PA Chest ☐ RT ☐ LT
☐ RIBS, bil, w/PA Chest
☐ Sternum

Spine and Pelvis

☐ Cervical Sp. (AP & LAT)
☐ Cervical Sp. (fix/ext) only
☐ Cervical Sp. Comp.
☐ Thoracic Sp. (AP & LAT)
☐ Thoracic Lumb Jct only
☐ Lumb Sp AP & LAT
☐ Lumb SAC Comp (w/obls)
☐ Lumb SAC flex/ext only
☐ Pelvis, AP

Abdomen

☐ ABD (1 vw)
☐ ABD (2-3 vws)
☐ ABD Comp (Series/w/PA Cxr)
☐ Other: __________
____
____
____
____
____
____
____
____

Upper Extremities

☐ Clavicle ☐ RT ☐ LT

☐ Scapula ☐ RT ☐ LT

☐ Shoulder (1 vw) ☐ RT ☐ LT

☐ Shoulder Comp (≥2 vws) ☐ RT ☐ LT
☐ Humerus ☐ RT ☐ LT

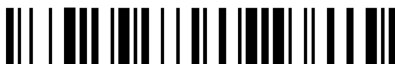
☐ Elbow, (AP & LAT) ☐ RT ☐ LT
☐ Elbow, Comp (≥ 3 vws) ☐ RT ☐ LT
☐ Forearm, (AP & LAT) ☐ RT ☐ LT
☐ Wrist Comp (≥ 3 vws) ☐ RT ☐ LT
☐ Hand (≥ 3 vws) ☐ RT ☐ LT
☐ Finger(s) RT 1 2 3 4 5
☐ Finger(s) LT 1 2 3 4 5

Lower Extremities

☐ Hip, Comp (≥ 2 vws) ☐ RT ☐ LT
☐ Hip, Bilat, w/AP of Pelvis ☐ RT ☐ LT

☐ Femur (AP & LAT) ☐ RT ☐ LT
☐ Knee, (AP & LAT, w/obls) ☐ RT ☐ LT
☐ Knee, Comp w/Patella ☐ RT ☐ LT
☐ Tib Fib ☐ RT ☐ LT

☐ Ankle, Comp (≥ 3 vws) ☐ RT ☐ LT
☐ Foot, Comp (≥ 3 vws) ☐ RT ☐ LT
☐ Toe(s) RT 1 2 3 4 5
☐ Toe(s) LT 1 2 3 4 5



ORDERS FR264 604 (01/2012)

Imaging Patient Appointment Instructions

Patient appointments

If your physician's office has requested that you schedule your own Imaging appointment, please call (559) 450-6742.

Patient instructions

You may be contacted by the Imaging staff to discuss exam prep information and instructions.

Patient arrival

Please arrive 30 minutes prior to your appointment time unless otherwise specified. Please bring any pertinent studies and reports with you on the day of the exam.

Please follow the examination preps listed unless otherwise specified by your physician.

Ultrasound of the pelvis/obstetric

Drink four, 8-ounce glasses of water, finish one hour before your examination and do not urinate.

Ultrasound abdomen, gall bladder, aorta

Nothing by mouth 8 hours prior to examination time. May take medications with small amount of water.

CT scan

Nothing to eat or drink 4 hours prior to your exam if IV contrast will be given.

MRI

No patients with pacemakers, aneurysm clips in the head, cochlear implants, implanted devices, pumps or stimulators. No hair products after last wash. No eye make-up. No lotions. Nothing to eat or drink 4 hours prior to your study.

Notify secretary at time of scheduling if:

1. Patient needs sedation.
2. There is a possibility of metallic foreign body in the eye.
3. Pateint is breastfeeding.

Location

- Saint Agnes Imaging Center
  1510 E. Herndon Ave., Suite 110
  (559) 450-6742

  Use second floor west entrance and take stairs or elevator to first floor lobby.

Imaging Center Location