

DOCs

DIAGNOSTIC OUTPATIENT CENTERS, INC.

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APPOINTMENT INFORMATION

App't Date: _____

Time: _____ AM PM

Physician's Request

Patient's Name _____

Clinical History/DX _____

MRI

HEAD	SPINE	UPPER EXTREMITIES	LOWER EXTREMITIES
<input type="checkbox"/> Brain	<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> Shoulder <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/> Pelvis <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B
<input type="checkbox"/> Brain Stem	<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/> Elbow <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/> Hip <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B
<input type="checkbox"/> I.A.C.'s	<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/> Wrist <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/> Knee <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B
<input type="checkbox"/> Orbits	MRA	<input type="checkbox"/> Hand <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/> Ankle <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B
<input type="checkbox"/> Pituitary	<input type="checkbox"/> Intracranial (Brain)	<input type="checkbox"/> Other Extremity _____	<input type="checkbox"/> Foot <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B
<input type="checkbox"/> Posterior Fossa	<input type="checkbox"/> Neck (Carotid)		<input type="checkbox"/> Other _____
<input type="checkbox"/> Sinuses		CONTRAST <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> TMJs	Other _____		

DIAGNOSTIC ULTRASOUND

ABDOMEN	VASCULAR	NOTES
<input type="checkbox"/> Abdominal Ultrasound Complete	<input type="checkbox"/> Carotid Ultrasound	
<input type="checkbox"/> Abdominal Ultrasound Limited (Specify Organ) _____	<input type="checkbox"/> Bilateral lower extremity arterial duplex (includes ABI)	
<input type="checkbox"/> Aorta Ultrasound	<input type="checkbox"/> Lower extremity venous duplex Bilateral <input type="checkbox"/> Left <input type="checkbox"/> Right	
<input type="checkbox"/> Renal Ultrasound	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Other _____		
OB/GYN	OTHER	
<input type="checkbox"/> Pelvic Ultrasound and Transvaginal if necessary	<input type="checkbox"/> Breast Ultrasound <input type="checkbox"/> Left <input type="checkbox"/> Right	
<input type="checkbox"/> Pregnancy Ultrasound (1st Trimester) and Transvaginal if necessary	<input type="checkbox"/> Thyroid Ultrasound	
<input type="checkbox"/> OB Ultrasound Complete (2nd & 3rd Trimester)	<input type="checkbox"/> Testicular Ultrasound	
<input type="checkbox"/> OB Ultrasound F/U	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Other _____		

MULTI-SLICE CT SCAN

HEAD	ABDOMEN	UPPER EXTREMITIES	CTA	RECONSTRUCTION
<input type="checkbox"/> Brain	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Shoulder <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Brain	<input type="checkbox"/> Sagittal or Coronals
<input type="checkbox"/> Sinus	<input type="checkbox"/> ABD/Pelvis	<input type="checkbox"/> Elbow <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Carotid	<input type="checkbox"/> 3D/4D
<input type="checkbox"/> Temporal Bones	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Wrist/Hand <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Chest	
<input type="checkbox"/> Facial Bones Orbits	<input type="checkbox"/> Urogram		<input type="checkbox"/> Aorta	
<input type="checkbox"/> TMJs		LOWER EXTREMITIES	<input type="checkbox"/> RUNOFF	
<input type="checkbox"/> Neck		<input type="checkbox"/> Hip <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Renals	
SPINE	THORAX	<input type="checkbox"/> Femur <input type="checkbox"/> L <input type="checkbox"/> R	CONTRAST	
<input type="checkbox"/> Cervical	<input type="checkbox"/> Chest	<input type="checkbox"/> Knee/Patella <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> With Contrast	
<input type="checkbox"/> Thoracic	<input type="checkbox"/> High Resolution (HRCT)	<input type="checkbox"/> Lower Leg <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Without Contrast	
<input type="checkbox"/> Lumbar	<input type="checkbox"/> P.E. Study	<input type="checkbox"/> Ankle/Foot <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> With and Without Contrast	
			<input type="checkbox"/> Without Oral	

*PLEASE SEE REVERSE SIDE FOR EXAMINATION INSTRUCTIONS

NPI# _____ Physician's Signature _____

EXAM PREPARATION- ALL EXAMINATIONS (VERY IMPORTANT)

Should you be pregnant or have any dietary needs (ie. diabetic and/or necessary medications) please inform our office when you are scheduling your appointment.

1) MRI:

Patients with pacemakers, defibrillators, intracranial metal clips, heart valves, or any type of prostatic devices must inform our scheduler when scheduling their appointment. In the event you have such hardware, a CT exam maybe the correct alternative examination.

2) CT:

If you are having a CT Exam of the Abdomen or Pelvis, it will be necessary that you drink and oral contrast solution. You may pick up contrast at our facility up to one day prior to your examination. Instructions will be given to you by our office staff, when you pick up your contrast.

If you are over the age of 65 and you are to have an examination with contrast, you will need laboratory blood work completed (BUN and creatnin levels) no longer than 90 days prior to your examination. Our staff will provide you any needed instructions.

3) ULTRASOUND:

Abdominal Ultrasound: No eating or drinking after midnight, unless you have special dietary or medication needs.

Pelvic Ultrasound: 32 oz. water 1 hour prior to study.

1st Trimester: 32 oz. water 1 hour prior to ultrasound.

OB 2nd, 3rd Trimester: 20 oz. clear fluid 1 hour prior to ultrasound.

Renal Ultrasound: Patient should be well hydrated.

Arteral or Venous- No preparation is needed.

4) Insurance companies require a referral and a pre-authorization number for diagnostice testing. It is a requirement by your insurance company to have your services pre-authorized especially MRI, CT, and Ultrasound studies. This authorization process can delay your examination from being as timely as possible. Thank you for your cooperation in advance. This is required by your insurance carrier, not by DOCs.

