TWO LOCATIONS IN MERCED
3365 G Street, Suite 100 • 1390 E. Yosemite Avenue, Suite A
Phone: (209) 384-4250 • Fax: (209) 384-4269

Patient Name ______________________ Date of Birth ______________ Height _____ Weight ____
Patient Phone # ______________________ Appointment Date ______________ Arrival Time ______________
Referring Provider ______________________________
Office Phone (   ) ______________________ Fax (   ) ______________________

SPECIAL INSTRUCTIONS

☐ Routine ☐ STAT Please provide **PHONE NUMBER** for use **AFTER 5 PM** ______________________

Diagnosis/History: ____

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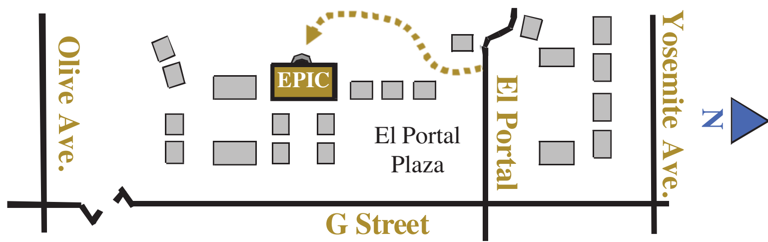
MRI			
☐ Brain (routine)	☐ Cervical Spine	☐ Knee Right / Left	☐ Abdomen (includes liver, spleen, pancreas, gallbladder)
☐ Brain (without contrast)	☐ Thoracic Spine	☐ Shoulder Right / Left	
☐ IAC's	☐ Lumbar Spine	☐ Ankle Right / Left	☐ MRCP (common bile duct)
☐ Pituitary	☐ Sacrum	☐ Hip Right / Left	☐ Pelvis
☐ MRA Circle of Willis (Brain)	☐ Coccyx	☐ Elbow Right / Left	☐ MRA Abdomen ☐ MRA Renals
☐ MRA Carotids (Neck)		☐ Wrist Right / Left	☐ MRA Abdominal Aorta w/runoff
☐ Neck Soft Tissue	☐ Breast Bilateral	☐ Extremity Upper / Lower	
☐ TMJ's	☐ Breast Unilateral Right / Left	(specify extremity) ______________	☐ Other ______________
CT			
☐ Brain	☐ Chest	☐ Urinary Tract	☐ Joint Right / Left
☐ Brain (without IV contrast)	☐ Chest (without IV contrast)	☐ Urinary Tract (without IV contrast)	(specify joint) ______________
☐ Sinuses	☐ Chest (High Resolution)	☐ Thoracic Aorta (CTA)	☐ Bone Right / Left
☐ Mastoids	☐ Abdomen	☐ Abdominal Aorta (CTA	(specify area) ______________
☐ Orbits ☐ Facial Bones	☐ Abdomen (without IV contrast)	☐ Abdominal / Pelvic Aorta (CTA)	☐ CT Arthrogram
☐ Soft Tissue Neck	☐ Pelvis	☐ Abdominal / Pelvic / Extremities (CTA)	(specify joint) ______________
☐ Spine (specify area) ______________	☐ Pelvis (without IV contrast)		☐ Other
Diagnostic Radiology (Specify body part including R,L, and Bilateral			
☐ Chest (1 view)	☐ Cervical Spine (complete / limited)	☐ Hip Right / Left	☐ Nasal Bones
☐ Chest (2 view)	☐ Thoracic Spine	☐ Femur Right / Left	☐ Mandible
☐ Ribs Right / Left / Bilateral	☐ Lumbar Spine (complete/limited)	☐ Knee Right / Left	☐ Shoulder Right / Left
☐ Neck Soft Tissue	☐ Sacrum & Coccyx	☐ Tibia & Fibula Right / Left	☐ Humerus Right / Left
☐ Sinus Series	☐ Sacro-Iliac Joints	☐ Ankle Right / Left	☐ Elbow Right / Left
☐ Abdomen (complete)	☐ Scoliosis Series	☐ Foot Right / Left	☐ Forearm Right / Left
☐ Abdomen (1 view - KUB)	☐ Bone Survey	☐ Os Calcis (Heel) Right / Left	☐ Wrist Right / Left
☐ Pelvis	☐ Bone Age	☐ Other __________ Right / Left	☐ Hand Right / Left
☐ Barium Swallow	☐ Clavicle	☐ Skull Complete / Limited	☐ Fingers Right / Left
☐ UGI ☐ UGI/SBS	☐ Sternum	☐ Orbits ☐ Facial Bones	☐ Other ______________
Ultrasound			
☐ Abdomen ☐ Liver Elastography	☐ Fetal Nuchal Translucency	☐ Venous Upper Extremity Right / Left	☐ Breast Right / Left
☐ Urinary Tract	☐ Thyroid	☐ Venous Lower Extremity Right / Left	☐ Breast Screening Right / Left
☐ Pelvis	☐ Testicular	☐ Arterial Upper Extremity Right / Left	
☐ Pelvis with Endovaginal	☐ Abdominal Aorta	☐ Arterial Lower Extremity Right / Left	
☐ Obstetrical (OB)	☐ Carotid	☐ Venous Insufficiency Right / Left (circle)	☐ Other ______________
Mammography			
☐ Screening Bilateral / Unilateral R / L	☐ Diagnostic Bilateral / Unilateral R / L		
Nuclear Medicine			
☐ Bone Scan (whole body,limited,3 phase)	☐ Liver/Spleen	☐ Thyroid scan only (99mTc-pertechnetate)	☐ VQ Lung Scan
☐ Hepatobiliary (HIDA) - (with EF images)	☐ Helicobacter Pyloric Breath Test	☐ Thyroid scan with Uptake (123-Iodine)	☐ Perfusion Lung Scan only
☐ White Blood Cell (Ceretc WBC's)	☐ Gastric emptying (Solid) (Dual Phase)	☐ Parathyroid scan	☐ MUGA (Resting Cardiac Assmt)
☐ White Blood Cell (111-Indium WBC's)	☐ Meckel's Diverticulum Imaging	☐ Sentinel Node Localization Study	☐ Bone Marrow Imaging
	☐ Gastrointestinal Bleed Study	☐ Somatostatin Receptor (Octreotide)	☐ Other ______________
PET (please indicate if exam is for) Diagnosis __ Staging __ Restaging __			
☐ Whole Body	☐ Limited	☐ Melanoma	☐ Brain

Provider Signature ________________________________ Date ______________

Important Patient information on back of this form.



Instructions

- Be sure to follow instructions for your exam preparation. Please bring the following items with you to your appointment
  - ⇨ Insurance card ⇨Physician's order ⇨Prior imaging/x-ray/mammogram examination
- Please be sure any precertification requirements of your healthplan are met prior to your appointment.
- You will be asked to arrive 15 - 30 minutes prior to your appointment.
- Exam results will be sent to your physician within 48 hours.
- If you need your films for an appointment, please call us 24 hours in advance.
- If you have any questions about preparation or your exam, please contact us at the phone number listed above.

Exam Preparations

- **MRI**
  - ⇨ Assure that you **Do NOT** have a pacemaker or brain aneurysm clip. Notify staff if you have any metal anywhere in your body. Please arrive well-hydrated (2-4 glasses of water) as some exams may require an IV contrast injection.
- **CT**
  - ⇨ Please drink 4-6 glasses of water starting four hours prior to your exam. **Do NOT** eat anything for at least three hours prior to the exam.
- **NUCLEAR MEDICINE & PET EXAMINATIONS**
  - ⇨ Please call office for exam instructions. Please avoid contact with pregnant women & small children for 24 hours after your injection.
- **XRAY**
  - ⇨ Please call office for exam instructions.
- **ULTRASOUND**
  - ⇨ **ABDOMEN /GALLBLADDER/ ABDOMEN DOPPLER/AORTA ULTRASOUND:** Do not eat any food 12 hours prior to your exam. Do not drink any fluid 2 hours prior to your exam. No carbonated drinks, gum chewing or smoking.
  - ⇨ **RENAL/KIDNEY ULTRASOUND:** Drink 4 glasses of water one hour prior to appointment. Do not empty bladder. Bladder must be full for exam.
  - ⇨ **PELVIC/OB ULTRASOUND:** Drink 4 glasses of water one hour prior to appointment. Do not empty bladder. Bladder must be full for exam.
- **MAMMOGRAM:**
  - ⇨ **Do NOT** use deodorant, powder, or perfume prior to exam.

** If you are **ALLERGIC to IODINE** or **IVP DYE,**
notify our office **PRIOR** to your appointment
** If you are **DIABETIC, Do NOT** take **GLUCOPHAGE**
for **48 HOURS AFTER** your exam