# AZ | TX ADVANCED IMAGING

**SCHEDULING PHONE: 844-641-2111**
**EMAIL: SUPPORT@TXADVANCEDIMAGING.COM**

RadSite ACCREDITED

Hablamos Español

| | | |
|---|---|---|
| ☐ **Katy- OPEN MRI, CT, US, X-Ray -** 954 S Fry Rd Katy, TX 77450 | **P** 832-240-3757 | **F** 832-581-4314 |
| ☐ **Conroe-OPEN MRI, CT, US, X-Ray -** 200 River Pointe Drive Ste 130, Conroe TX 77304 | **P** 832-365-5085 | **F** 832-365-7977 |
| ☐ **Sugar Land-MRI, CT, US, X-Ray -** 1111 Highway 6 Ste 50, Sugar Land TX 77478 | **P** 832-553-0190 | **F** 832-581-4312 |
| ☐ **Jersey Village- OPEN MRI** 17482 NW Freeway Suite A, Jersey Village TX 77040 | **P** 713-856-5955 | **F** 713-856-7107 |
| ☐ **Tomball- MRI, CT, US, X-Ray -** 444 Holderrieth Blvd, Suite 1, Tomball TX 77375 | **P** 281-255-6850 | **F** 281-819-2151 |

## Please bring this completed order, your insurance card, and a photo ID with you to your appointment

Today's date: _____ Appointment date: _____ Appointment time: _____

Patient Name: _____ DOB: ___ / ___ / _____ ☐ M or ☐ F Patient Phone: _____
*(Last) (First)* *MM DD YYYY*

Diagnosis/Current Symptoms/History: _____ ICD 10 Code: _____

Physician Signature: _____ Phone: _____ Fax: _____

Print Physician Name: _____

Attorney Name: _____ Phone: _____ Fax: _____

Case Manager: _____

Additional Report to: _____ ☐ **MVA/PI** ☐ **Transportation Needed** ☐ **WC** **DOI** _____ ☐ **STAT**
*(Available for PI cases only)*

Insurance carrier: _____ ID #: _____

## MRI
*(with reconstruction as indicated)*

- ☐ Brain
- ☐ Brain & IAC
- ☐ Brain & Pituitary
- ☐ IAC Only
- ☐ Pituitary Only
- ☐ Orbits
- ☐ Neck Soft Tissue
- ☐ Spine:
  - cervical _____
  - thoracic _____
  - lumbar _____
- ☐ Abdomen (Indicate area of interest below)

_____

- ☐ MRCP
- ☐ Adrenals
- ☐ Pelvis

- ☐ Extremity: Left ___ Right ___
  - body part: _____
- ☐ **Other:**

_____

- ☐ **Without contrast**
- ☐ **With & without contrast**

- ☐ SWI
- ☐ TBI
- ☐ DTI

### MR Angiography (MRA)

- ☐ Brain
- ☐ Neck Carotids
- ☐ Chest
- ☐ Aorta
- ☐ Renals
- ☐ **Other:** _____
- ☐ **Without contrast**
- ☐ **With & without contrast**

## CT
*(with reconstruction as indicated)*

- ☐ Head / Brain
- ☐ Temporal Bones (IAC's)
- ☐ Sinus (Maxillofacial)
  - complete ___ limited ___
- ☐ Maxillofacial – Facial Bones
- ☐ Neck Soft Tissue
- ☐ Shoulder: Left ___ Right ___
- ☐ Spine:
  - cervical _____
  - thoracic _____
  - lumbar _____
- ☐ Chest
- ☐ Abdomen (pelvis as indicated)
- ☐ Pelvis
- ☐ CT Urogram
- ☐ CT Stone Protocol
- ☐ Hip: Left ___ Right ___
- ☐ Extremity: Left ___ Right ___
  - Indicate area of interest: _____
- ☐ **Other:**

_____

- ☐ **With contrast**
- ☐ **Without contrast**
- ☐ **With & without contrast**

### CT Angiography *(w & w/o contrast)*

- ☐ Head / Brain
- ☐ Neck - Carotids
- ☐ Chest
- ☐ Abdomen (pelvis as indicated)
- ☐ Pelvis
- ☐ **Other:**

_____

## X-RAY

- ☐ Skull
- ☐ Orbits
- ☐ Sinuses:
  - waters _____
  - limited _____
  - complete _____
- ☐ Shoulder: Left ___ Right ___
- ☐ Neck Soft Tissue
- ☐ Chest: PA ___ PA/LAT ___
- ☐ Ribs (w/ PA Chest):
  - Left ___ Right ___
- ☐ Spine: ☐ Add Flex/Ext
  - cervical ___
  - thoracic ___
  - lumbar ___
- ☐ KUB
- ☐ Acute Abdominal Series
- ☐ Hip: Left ___ Right ___
- ☐ Bilateral Hips (w/ pelvis)
- ☐ Pelvis
  - Indicate area of interest: _____
- ☐ **Extremity:** Left ___ Right ___

- ☐ **Other:**

_____

## ULTRASOUND
*(with reconstruction as indicated)*

- ☐ Carotid Doppler
- ☐ Venous Doppler
  - upper extremity: Left ___ Right ___
  - lower extremity: Left ___ Right ___
- ☐ Abdominal Aorta
- ☐ Abdomen
- ☐ Abdomen Limited:
  - gallbladder ___
  - hernia _____
  - appendix ___
- ☐ Renal / Bladder
- ☐ Pelvic
- ☐ Scrotum
- ☐ Thyroid
- ☐ Follow Up

Reason:

_____

- ☐ **Other:**

_____

- ☐ Prior Imaging Report, CD
- ☐ Bring attorney's information or business card
- ☐ Personal and At-Fault (3rd Party Insurance Information)
- ☐ Police Report or Collision Exchange Form
- ☐ Call Report to Physician: _____
  *Physician's Direct Phone Number*

**For us to obtain prior authorization please fax insurance card front and back**

# GENERAL INSTRUCTIONS

## ULTRASOUND

**Gallbladder and/or Abdomen:** Nothing to EAT or DRINK after midnight. Water is OK.

**Pelvic:** 1 hrs prior to exam, empty bladder (urinate). Start drinking 24 ounces of water. Finish water in 30 minutes. Do not empty bladder until exam is completed.

**Renal:** Drink 16 ounces of water 30 minutes prior to exam. Do not empty bladder prior to exam.

## CT SCAN

CT Exams Requiring IV Contrast: Nothing to EAT or DRINK 4 hours prior to exam.

CT Exams Requiring Oral Contrast: Nothing to EAT or DRINK 4 hours prior to exam. Patients may pick up oral contrast at the facility prior to the appointment or arrive 1 hour prior to the exam. Please confirm your selection when scheduling your appointment.

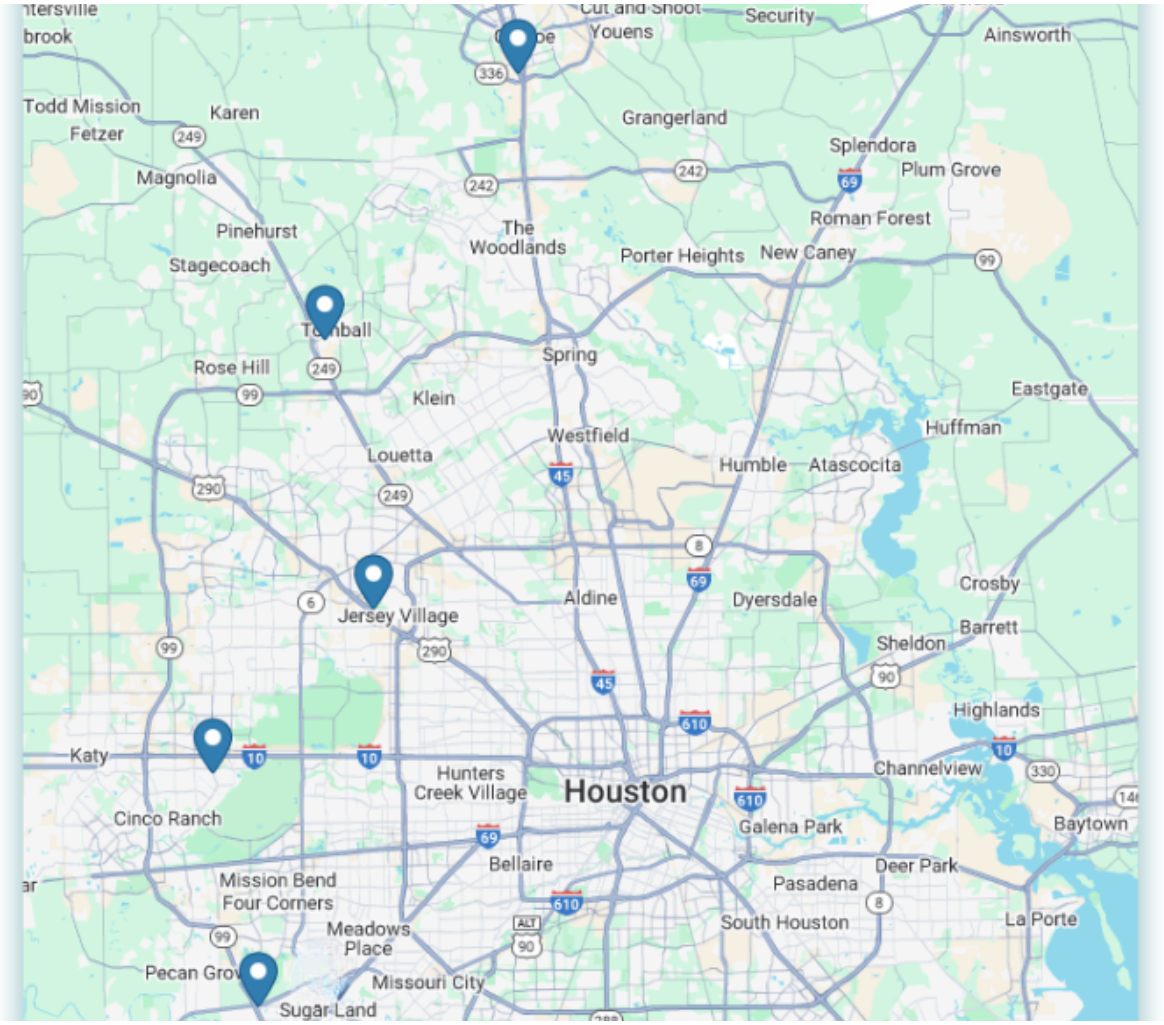
*** Some CT exams require both oral and IV contrast. In addition, some CT exams require lab work prior to your visit, please inquire when scheduling.

## MRI

**All MRI Exams:** Notify office immediately if you have a **cardiac pacemaker, aneurysm clip, AICD (Cardiac Defibrillator), implanted device of any kind, or possible metal in your eye.**

**MRI of the Abdomen:** Nothing to Eat or Drink 4 hours prior to the exam.

***Some MRI exams require lab work prior to your visit, please inquire when scheduling.

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