

**Diagnostic Imaging Services  
 Patient Referral**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Clinical Indications \_\_\_\_\_

Referring Dr. \_\_\_\_\_

Copy of Films Requested Y  N

<input type="checkbox"/> <b>HIGH FIELD MRI SCAN</b>	<input type="checkbox"/> <b>OPEN MRI</b>
<input type="checkbox"/> <b>Brain</b> <input type="checkbox"/> With Contrast <input type="checkbox"/> MR Spectroscopy <input type="checkbox"/> Diffusion <input type="checkbox"/> Perfusion <input type="checkbox"/> IACs <input type="checkbox"/> Orbits <input type="checkbox"/> Neck (Soft Tissue) <input type="checkbox"/> Pituitary <input type="checkbox"/> TMJs <input type="checkbox"/> <b>Spine</b> <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> With Contrast <input type="checkbox"/> <b>MR Angiography</b> <input type="checkbox"/> Carotid <input type="checkbox"/> Cerebral <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>MR Angiography with Contrast</b> <input type="checkbox"/> Aorta <input type="checkbox"/> Renals <input type="checkbox"/> Lower Extremities <input type="checkbox"/> Carotid <input type="checkbox"/> Other _____	<input type="checkbox"/> Shoulder R / L <input type="checkbox"/> Elbow R / L <input type="checkbox"/> Wrist R / L <input type="checkbox"/> Hip R / L <input type="checkbox"/> Knee R / L <input type="checkbox"/> Ankle/Hindfoot R / L <input type="checkbox"/> Forefoot/Toes R / L <input type="checkbox"/> Abdomen <input type="checkbox"/> Liver <input type="checkbox"/> Kidney <input type="checkbox"/> MRCP <input type="checkbox"/> Pelvis <input type="checkbox"/> Chest <input type="checkbox"/> MR Mammography <input type="checkbox"/> Other _____ <b>Special Instructions:</b> _____ _____ <b>Contraindications:</b> Cardiac Pacemaker, Spinal Cord Stimulator, Cerebral Aneurysm Clip, Ear Implant, Metallic Fragments in Eye, Drug Infusion Pump, Cardiac Defibrillator, Pregnancy.

<b>COMMACK OFFICE: 631-4994233</b>	
<input type="checkbox"/> <b>BONE DENSITOMETRY</b>	
<input type="checkbox"/> <b>LOW DOSE MAMMOGRAPHY</b>	
<b>FLUOROSCOPY</b>	<input type="checkbox"/> IVP
<input type="checkbox"/> Esophagram	Bun _____ Creatinine _____
<input type="checkbox"/> Small Bowel	<input type="checkbox"/> Other _____
<b>X-RAY</b>	<input type="checkbox"/> Shoulder R/L
<input type="checkbox"/> Skull	<input type="checkbox"/> Humerus R/L
<input type="checkbox"/> Orbits	<input type="checkbox"/> Elbow R/L
<input type="checkbox"/> Facial Bones	<input type="checkbox"/> Forearm R/L
<input type="checkbox"/> Nasal Bones	<input type="checkbox"/> Wrist R/L
<input type="checkbox"/> C Spine	<input type="checkbox"/> Hand R/L
<input type="checkbox"/> T Spine	<input type="checkbox"/> Fingers R/L
<input type="checkbox"/> L Spine	<input type="checkbox"/> Hips R/L
<input type="checkbox"/> Sacrum	<input type="checkbox"/> Femur R/L
<input type="checkbox"/> Chest	<input type="checkbox"/> Knee R/L
<input type="checkbox"/> Ribs	<input type="checkbox"/> Tibia/Fibula R/L
<input type="checkbox"/> F/U Abdomen	<input type="checkbox"/> Ankle R/L
<input type="checkbox"/> KUB Abdomen	<input type="checkbox"/> Foot R/L
<input type="checkbox"/> Pelvis	<input type="checkbox"/> Toes R/L
<input type="checkbox"/> Bone Age	<input type="checkbox"/> Other _____

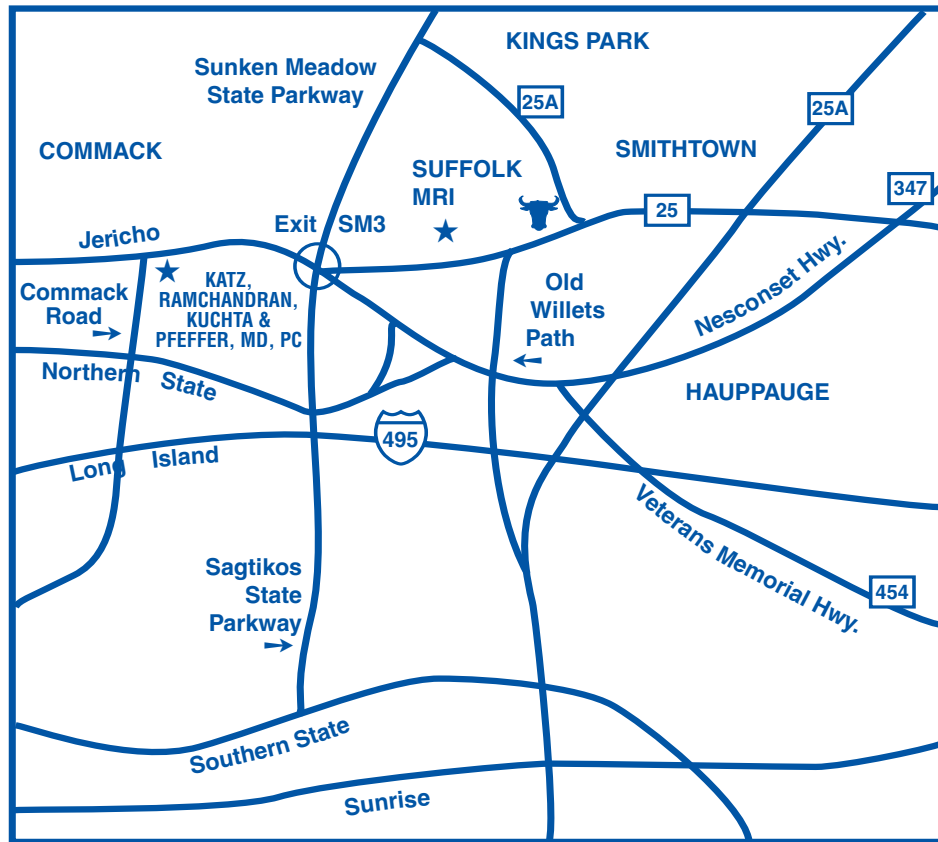
<b>CT SCAN (MULTISLICE)</b>	<input type="checkbox"/> <b>Oral Contrast</b>
<input type="checkbox"/> <b>IV Contrast</b> Bun _____ Creatinine _____	<input type="checkbox"/> Spine 3D Imaging Vertebral Levels: _____
<input type="checkbox"/> Brain	<input type="checkbox"/> Orthopedic CT 3D Imaging Joint _____
<input type="checkbox"/> Temporal Bone	Indications _____
<input type="checkbox"/> Orbits	<input type="checkbox"/> <b>CT Angiography</b>
<input type="checkbox"/> Sinuses	<input type="checkbox"/> Carotid
<input type="checkbox"/> Neck (Soft Tissue)	<input type="checkbox"/> Cerebral
<input type="checkbox"/> Chest	<input type="checkbox"/> Aorta
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Renal
<input type="checkbox"/> Pelvis	<input type="checkbox"/> Lower Extremity
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> <b>Spine</b>	<input type="checkbox"/> Lung Screening
<input type="checkbox"/> Cervical	<input type="checkbox"/> Cardiac Scoring
<input type="checkbox"/> Thoracic (Levels: _____)	
<input type="checkbox"/> Lumbar	
<input type="checkbox"/> Sacrum	

<b>ULTRASOUND</b>	<input type="checkbox"/> Breast R/L
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Pelvis	<input type="checkbox"/> Scrotal
<input type="checkbox"/> Obstetrical	<input type="checkbox"/> Aorta
<input type="checkbox"/> Biophysical Profile	Other _____
<input type="checkbox"/> Transvaginal	

<b>DOPPLER</b>	<input type="checkbox"/> Extremity Venous Study R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Carotid	
<input type="checkbox"/> Renal	
<input type="checkbox"/> Other _____	

<b>NUCLEAR MEDICINE</b>
<input type="checkbox"/> Bone Scan - Whole Body
<input type="checkbox"/> Bone Scan - Three Phase (attention) _____
<input type="checkbox"/> Gallium Scan
<input type="checkbox"/> Gastric Emptying Scan
<input type="checkbox"/> Hida Scan without CCK _____ with CCK _____
<input type="checkbox"/> Liver/Spleen Scan
<input type="checkbox"/> MUGA Scan
<input type="checkbox"/> Liver Scan (tagged RBC's, R/O Hemangioma)
<input type="checkbox"/> Renal Scan
<input type="checkbox"/> Thyroid Uptake and Scan
<input type="checkbox"/> Parathyroid Scan
<input type="checkbox"/> Lung Perfusion Scan
<input type="checkbox"/> Other _____

**Special Instructions:**



## EXAM PREPARATION

### MRI

Wear comfortable clothing that does not contain metal. Please do not wear jewelry or metal hair clips, pins or eye makeup. If you have a **pacemaker, aneurysm clips, or ear implant** an MRI can **NOT** be performed.

### CT

When scheduling appointment the facility will advise what preparation to follow.

### MAMMOGRAPHY

Do not wear deodorant or talcum powder on date of exam. If previous mammography was performed elsewhere, please obtain a copy and bring it with you on date of exam.

### GI SERIES/ SMALL BOWEL SERIES

Nothing to eat, drink, chew or smoke from midnight the evening before until after the exam.

### IVP

The night before the exam mix 3 tablespoons of Fleet's Phospho-soda in a full glass of water and drink. Nothing to eat or drink the morning of the exam.

### BARIUM ENEMA

Instructions for this exam must be obtained at the office 3 days prior to exam.

### ULTRASONOGRAPHY:

#### ABDOMEN

Nothing to eat, drink, chew or smoke for 6 hours prior to exam.

#### PELVIS/OBSTETRIC

Two hours prior to the exam empty bladder. Within 15 minutes drink 26 oz. of water. Do **NOT** empty bladder again until after the exam.

### NUCLEAR MEDICINE

Instructions for nuclear medicine testing will be given when the appointment is scheduled.

### OTHER ULTRASOUND EXAMS

No preparation.

***IF YOU ARE PREGNANT NOTIFY OUR OFFICE WHEN SCHEDULING YOUR APPOINTMENT.***