High Tech Imaging Center, Inc. at Neuro Spine Institute

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Innovation Drives Us • Competition Guides Us

Patient Name:____________________ D.O.B.__________

Patient Phone: ____________ Email: ____________

Appointment Date:__________ Time__________ A.M. P.M.

Physician __________ Physician's Signature: __________

Diagnosis: ____________________

Physician's Phone #__________ Fax # __________

___ Return patient to my office ___Written Report

___ Please send ☐ film or ☐ CD with patient ___Please send films to my office

___ Stat report requested

PLEASE INCLUDE THE FOLLOWING INFORMATION FOR INSURANCE VERIFICATION & PRE-VERIFICATION:

Primary Insurance/WC__________ Phone__________ ID/Case#__________

☐ Precert Request: Please fax order, patient demographic, insurance, Lab and clinical notes to 334-241-8844. Physician's NPI# __________

Tax ID#__________

☐ If you have precerted, please supply auth # here __________.

Please bring this referral sheet with you as well as insurance cards and ID card (Driver's license, military ID, etc.) and a compact disc or cassette of your favorite music to listen to during your scan. Wear comfortable clothing, free of metal, if possible, and remove all jewelry. There are no dietary restrictions for MRI.

MRI- Magnetic Resonance Imaging

Choose Machine: ____ Open ___ 1.5T shortbore

______ ABD
______ Brain
______ IAC's
______ Orbits
______ Pituitary
______ Cervical Spine
______ Thoracic Spine
______ Lumbar Spine
______ Pelvis
______ Hip Right Left
______ Shoulder Right Left
______ Knee Right Left
______ Wrist Right Left
______ Lower extremity Right Left
______ Upper extremity Right Left
______ Other __________

____w/o contrast
____w &w/o contrast
____w contrast

MRA

_____ Head
_____ Neck
_____ ABD
_____ Pelvis

Pre-study Lab Testing

☐ Bun/Creatinine

CT- Computerized Tomography

If the patient is having a test requiring contrast please note the following:

1. Diabetic patients taking **Glucophage** or **Metformin** may not resume medication for 48 hours after their exam. A BUN and CREATININE must be obtained ***prior to*** exam and then ***re-checked*** before continuing Glucophage or Metformin.
2. If the patient is over 60 he or she needs to obtain a BUN and **Creatinine** study. Bun_____ Creat_____ Date Drawn_____
3. Please notify if the patient has renal or heart problems.

☐ **BRAIN** ☐With or ☐Without
☐ **SINUS**
☐ **IAC's**
☐ **FACIAL BONES**
☐ **CT OTHER** __________

ROUTINE ABDOMEN/PELVIS ☐ With or ☐ Without
STONE SEARCH PROTOCAL ABDOMEN/PELVIS Without
ABDOMEN ☐ With or ☐ Without
PELVIS ☐ With or ☐ Without
3 PHASE ABDOMEN ☐ With or ☐ Without
ROUTINE CHEST WITH
ROUTINE CHEST WITH OUT
SPINE ☐ With or ☐ Without
☐ **CERVICAL** ☐ **THORACIC** ☐ **LUMBAR**

(Prep/pick-up Oral Prep the day before the exam from HTIC Imaging Center)

CTA ☐__________

SPECIAL INSTRUCTIONS:

Diagnostic Routine X-Rays

☐ Chest
☐ Abdomen Series
☐ KUB
☐ Ribs
☐ Skull
☐ Sinuses
☐ Cervical Spine
☐ Thoracic Spine
☐ Lumbar Spine
☐ Pelvis
☐ Extremity__________
☐ Ribs R or L __________
____
☐ Other__________
☐ Extremity R or L __________
____

SPECIAL INSTRUCTIONS:
____
____
____
____

Ultrasound

☐ ABI/Segmental Pressure
☐ Complete Abdomen (aorta, liver, GB, pancreas, spleen, bilateral kidneys) **PREP:** Nothing to eat or drink after midnight
☐ Limited Abdomen (GB, Liver, Pancreas) **PREP:** Nothing to eat or drink after midnight
☐ Renal **PREP:** Nothing to eat or drink after midnight
☐ Pelvis **PREP:** Drink at least 32 oz fluid on hour before exam. Do not void.
☐ Carotid
☐ Lower Extremity Venous Doppler: (Please circle) Bilateral Unilateral
☐ Lower Ext Arterial Doppler/ABI's
☐ OB
☐ Other__________
☐ Echo __________

SPECIAL INSTRUCTIONS:
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