



Patient's Name: _____ DOB: _____ Attorney: _____
 Cell Phone #: _____ Email: _____ Attorney Phone #: _____
 Insurance Name: _____ Date of Accident: _____
 Policy #: _____ Authorization #: _____ Claim #: _____

MRI

- Mars Protocol
- SPINE**
- Cervical 3- D Reconstruction
 Without Contrast
 With And Without Contrast
- Lumbar
- Thoracic
- Sacrum/Coccyx
- HEAD / FACE / NECK**
- Brain 3- D Reconstruction
 Without Contrast
 With And Without Contrast
- Orbits 3- D Reconstruction
 Without Contrast
 With And Without Contrast
- Pituitary
- IAC
- Neck Soft Tissue
- TMJ/Mandible
- MRA/MRV**
- Brain/COW 3- D Reconstruction
 Without Contrast
 With And Without Contrast
- Neck/Carotid
- Chest
- Pelvis Left
 Right
 Specify Area:
- Upper Extremity
- Lower Extremity
- Leg/Ankle/Foot & Runoff
- Abdomen
- BODY**
- Abdomen
- Breast Bilateral 3- D Reconstruction
 Without Contrast
 With And Without Contrast
- Breast Unilateral
- Chest/Brachial Plexus
- Pelvis/Prostate
- MRCP
- UPPER EXTREMITY**
- Elbow
- Finger Left
 Right
 3-D Reconstruction
 Without Contrast
 With And Without Contrast
- Forearm
- Hand
- Shoulder
- Wrist
- Humerus
- LOWER EXTREMITY**
- Ankle
- Foot Left
 Right
 3-D Reconstruction
 Without Contrast
 With And Without Contrast
- Tibia/Fibula
- Toe
- Heel
- Hip
- Knee
- Femur
- CT / CTA**
- SPINE**
- Cervical 3- D Reconstruction
 Without Contrast
 With And Without Contrast
- Lumbar
- Thoracic

CT / CTA (cont.)

- HEAD / FACE / NECK**
- Brain
- Orbit 3- D Reconstruction
 Without Contrast
 With And Without Contrast
- Sinus
- TMJ/Mandible
- Maxillofacial
- Neck Soft Tissue
- CTA Brain/COW
- CTA Neck/Carotid
- CHEST**
- Routine Chest
- CTA Chest
- ABDOMEN/PELVIS**
- Abdomen 3- D Reconstruction
 Without Contrast
 With And Without Contrast
 Oral Contrast
- Pelvis
- Abdomen/Pelvis
- Urogram
- CTA Abdomen
- CTA Abdomen/Pelvis
- CTA Abdominal Aorta Iliofemoral-Lower Extremities Runoff Left
 Right
 Specify Area:
- EXTREMITIES**
- Upper Extremities 3- D Reconstruction
 W/O Contrast
 W & W/O Contrast
- Lower Extremities
- CTA Upper Extremities
- CTA Lower Extremities

X-RAY

- KUB
- Abdomen AP/Oblique
- Abdomen Complete
- Abdomen Complete Decubitus
- Ankle 2 Views
- Ankle Complete 3 Views
- AC Joints Bil w/wo Weight Distraction
- Bone Age Studies
- Calcaneus 2 Views
- Clavicle Complete
- Cervical Spine 2 or 3 Views
- Cervical Spine 4 or 5 Views
- Cervical Spine 6 or more Views
- Chest Single View
- Chest 2 Views
- Chest Oblique View
- Chest w/Apical 3 Views
- Chest Complete 4 Views
- Chest Decubitus
- Elbow 2 Views
- Elbow Complete 3 Views

X-RAY (cont.)

- Eyes for Foreign Body
- Facial Bones Complete 3 Views
- Femur Views: 1 2
- Finger 2 Views
- Foot Views: 1 2
- Forearm 2 Views
- Hand Views: 1 2
- Hip Unilateral Views: 1 2-3 4
- Hip Bilateral Views: 2 3-4 5
- Humerus 2 Views
- Knee Views: 1-2 3
- Knee Complete
- Knees Bilateral (standing anteroposterior)
- Entire Spine AP
- Lumbosacral w/bending 2 or 3 views
- Lumbosacral Complete w/bending 6 views
- Lumbosacral 4 Views
- Lumbosacral 2 or 3 Views
- Mandible Partial less than 4 Views
- Mastoids Complete 3 Views
- Nasal Bones Complete 3 Views
- Neck Soft Tissue
- Orbit Complete 4 Views
- Osseous Survey Complete
- Pelvis Complete
- Pelvis 1 or 2 Views
- Ribs Unilateral 2 Views
- Ribs Unilateral PA
- Ribs Bilateral PA
- Sacrum/Coccyx 2 Views
- SI Joints 3 or more Views
- Scapula
- Scoliosis Eval. Skull, entire Spine-Sacral
- Shoulder 1 View
- Shoulder Complete 2 Views
- Sinus Complete 3 Views
- Skull Complete Minimum 4 Views
- Sternum 2 Views
- Sternoclavicular Joints 3 Views
- Tibia/Fibula 2 Views
- Thoracic Spine Views: 2 3 4
- Thoracolumbar Junction 2 Views
- Toes 2 Views
- TMJ Unilateral open & closed Mouth
- TMJ Bilateral open & closed Mouth
- Wrist 2 Views
- Wrist Complete 3 Views

WOMEN'S IMAGING

<p>DIGITAL MAMMOGRAPHY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Screening <input type="checkbox"/> Diagnostic <input type="checkbox"/> 3-D Tomosynthesis <input type="checkbox"/> Bilateral <input type="checkbox"/> Left <input type="checkbox"/> Right <p>DIAGNOSTIC BREAST ULTRASOUND</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bilateral <input type="checkbox"/> Left <input type="checkbox"/> Right 	<p>AUTOMATED BREAST ULTRASOUND SCREENING <i>(Specifically women with dense breast)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Bilateral <input type="checkbox"/> Left <input type="checkbox"/> Right <p>MRI BREAST</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bilateral <input type="checkbox"/> Left <input type="checkbox"/> Right <p>BONE DENSITY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dexa
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ULTRASOUND

- | | |
|---|---|
| <p>RADIOLOGY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Abdominal Complete <input type="checkbox"/> Abdominal Limited <input type="checkbox"/> Retroperitoneal Complete <input type="checkbox"/> Renal Limited <input type="checkbox"/> Pelvic Complete <input type="checkbox"/> Pelvic Limited <input type="checkbox"/> Transvaginal <input type="checkbox"/> Testicles/Scrotum <input type="checkbox"/> Thyroid/Parathyroid <input type="checkbox"/> Extremity Complete <input type="checkbox"/> Extremity Limited <input type="checkbox"/> Chest <p>CARDIAC ULTRASOUND</p> <ul style="list-style-type: none"> <input type="checkbox"/> Echocardiogram w/color Doppler <input type="checkbox"/> Echocardiogram w/o color Doppler | <p>VASCULAR ULTRASOUND</p> <ul style="list-style-type: none"> <input type="checkbox"/> Carotid <input type="checkbox"/> Bilateral Ext Venous Doppler <input type="checkbox"/> Limited/Unilateral Ext Venous Doppler <input type="checkbox"/> Upper Ext Arteries w/Doppler <input type="checkbox"/> Lower Ext Arteries w/Doppler <input type="checkbox"/> IVC/Aorta/Iliac Doppler <input type="checkbox"/> Renal Artery w/Doppler <input type="checkbox"/> Testicular w/Doppler <input type="checkbox"/> Abdominal Aorta w/Doppler <p>OB ULTRASOUND</p> <ul style="list-style-type: none"> <input type="checkbox"/> OB <14 Weeks Transabdominal <input type="checkbox"/> OB >14 Weeks Transabdominal <input type="checkbox"/> OB <18 Weeks Transabdominal <input type="checkbox"/> OB Follow Up Exam <input type="checkbox"/> OB Transvaginal <input type="checkbox"/> OB Biophysical Profile <p style="text-align: center;">DEXA</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dexa |
|---|---|

Physician Name: _____

Signature: _____

Phone #: _____

Fax #: _____

PATIENT PREPARATION

If you are 60 years or older and you are having an MRI or CT Scan with IV contrast we kindly request that you have bun/creatinine bloodwork done (no older than 60 days) to assess any kidney issues.

MRI SCANS:

No surgeries within 8 weeks prior to your exam.

Please call our office before your appointment if any of the following apply:

- Pacemaker
- Surgical Vascular Clips
- Neurostimulators
- IVC Filter
- Cochlear Implants
- Breast Tissue Expander
- Silver Backed Dermal Patches
- Any kind of Pump in your body

** If you have any kind of stent, ear implant, aneurysm clip and any type of metal. Please bring documentation identifying it.

** If you have any previous MRI exams or relevant diagnostic exams to correlate with the MRI ordered, please bring them with you for your appointment.

MRCP: No food or drink 8 hours prior to your exam.

CT SCANS:

Dialysis Patients: Patients currently on dialysis require blood work (BUN & Creatinine) no older than 60 days. Patients should have CT exam performed prior to dialysis treatment. Dialysis treatment is to be performed the same day after the appointment time or the next day to clear all contrast materials from the patients system.

Diabetic Patients: Patients who are diabetic require blood work (BUN & Creatinine) no older than 60 days. Patients taking Glucophage, Glucovance or any other medication containing metformin must discontinue use of this medication for the day of and 48 hours after the exam.

Asthma History: Patients who have any history of asthma require pre-medication. (Your doctor will write a prescription.) Patient must pick up medication from the pharmacy no later than noon the day before the scan.

Allergies: Patients with allergies to shellfish, seafood or iodine may require pre-medication. If the patient has itchiness/hives/rash pre-medicate the patient. If the patient has shortness of breath/closing of throat we cannot perform exam with contrast.

CT Scans with IV Contrast:

NOTHING to eat or drink 6 hours prior to the exam.

CT Scans for the Abdomen/Pelvis:

Please contact our office for further instructions as this may require additional preparation other than fasting.

X-RAY:

No preparation necessary.

DIGITAL/SCREENING MAMMOGRAMS:

- 1) No perfume, powder, lotion, or deodorant on the date of the exam.
- 2) Mammogram should be scheduled one week after your menstrual cycle.
- 3) Bring any previous mammogram films and radiologist report.

AUTOMATED BREAST ULTRASOUND SCREENING:

- 1) No perfume, powder, lotion, or deodorant on the date of the exam.

ULTRASOUND EXAMS:

Abdominal Area: (Gallbladder, Liver, Pancreas, Spleen, Aorta.)

NOTHING to eat or drink 8 hours prior to the exam.

Pelvic Transabdominal: (Ovaries, Uterus, Prostate, Bladder.)

MUST drink 32 ounces of water 1 hour prior to the exam. Your bladder must be full. Do not urinate before the exam.

Obstetrical: **More than 14 weeks,** drink 32 ounces of water 1 hour prior to your exam time.

Less than 14 weeks, drink 32 ounces of water 30 minutes before your exam time.

Breast: No perfume, powder, lotion, or deodorant on the date of the exam.

No preparation necessary for the following exams:

- | | |
|----------------|----------------------------|
| Renal (Kidney) | Testicles |
| Thyroid | Echocardiogram |
| Carotid | Vascular (Arterial/Venous) |

BONE DENSITY:

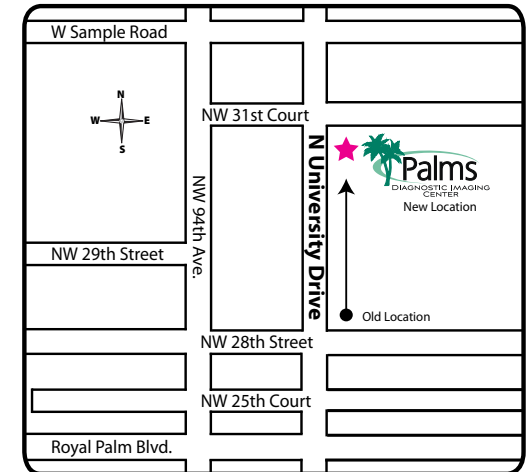
No recent IV/contrast, barium for at least 2 weeks prior to your scheduled appointment.

No preparation for the exam necessary.

***Please bring your insurance cards, referral/authorization and any previous films of the body area scanned with this prescription.**



Our new location at University Place



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