

NAME: _____ DATE OF BIRTH: ____/____/____

REPORTING INSTRUCTIONS:

Routine Report STAT Report

Fax # _____ Patient to return with CD

SYMPTOMS/DIAGNOSIS: _____ **ICD-10:** _____

IV CONTRAST STUDIES: BUN/CREATININE REQUIRED FOR ALL PATIENTS 65+, DIABETIC, OR HX OF RENAL DISEASE 30 DAYS PRIOR TO EXAM.

MRI

Patient Claustrophobic
 Study Without IV Contrast
 Study With & Without Contrast

NEUROLOGIC

BRAIN ORBITS/NECK/FACE IAC
 PITUITARY SOFT TISSUE NECK

SPINE

CERVICAL THORACIC LUMBAR

BODY

ABDOMEN RENAL PELVIS
 MRCP

EXTREMITY

	RT	LT	BILAT
<input type="checkbox"/> SHOULDER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> ELBOW	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> WRIST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> HIP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> KNEE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> ANKLE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> FOOT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> OTHER MRI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CT

Study Without IV Contrast
 Study With & Without IV Contrast

NEUROLOGIC

HEAD
 SOFT TISSUE NECK SINUSES

SPINE

CERVICAL THORACIC LUMBAR

BODY

CHEST ABDOMEN PELVIS
 PE STUDY 3-PHASE LIVER
 CT IVP (CT Urogram)
 CT RENAL STONE STUDY (Abd/Pelvis without contrast)
 EXTREMITY: _____

MR ANGIOGRAM | MR VENOGRAPHY

BRAIN CAROTID RENAL

MAMMOGRAPHY & BREAST ULTRASOUND

SCREENING RT LT BILAT
 DIAGNOSTIC RT LT BILAT

ULTRASOUND

BREAST RT LT BILAT

X-RAY

Use this box to indicate X-Ray type or other exams not listed.

X-RAY _____

ULTRASOUND

ABDOMEN COMPLETE ABDOMINAL AORTA
 THYROID RENAL/BLADDER PELVIS COMPLETE
 PELVIS W/TRANSVAGINAL
 OB EDC: _____ LMP: _____
 TESTICULAR/SCROTAL

VASCULAR

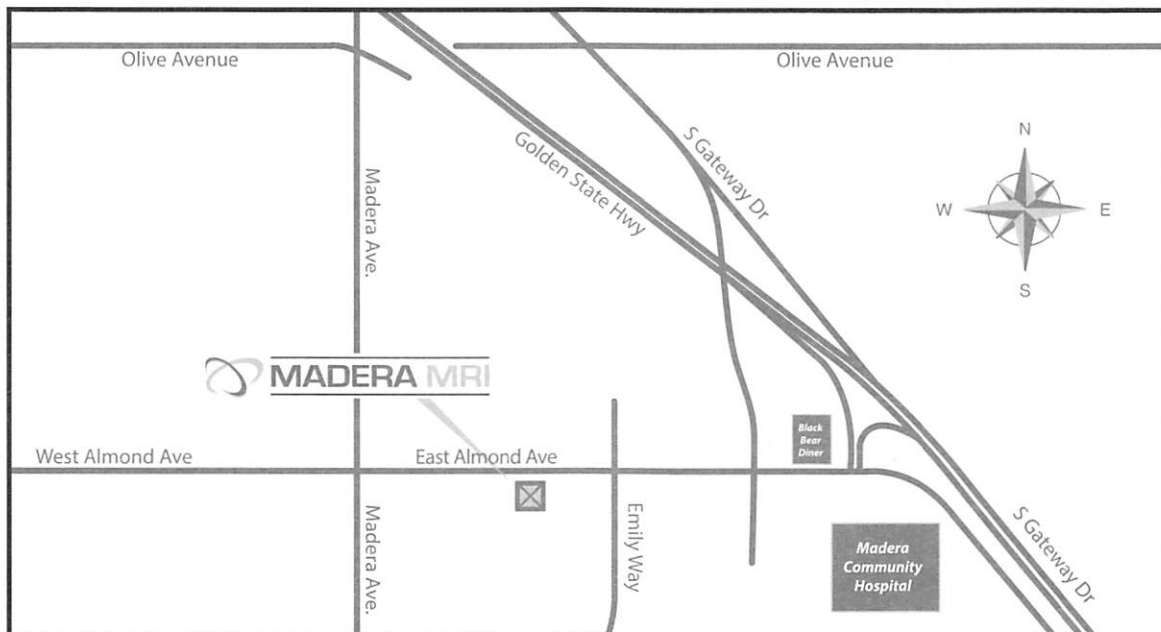
	RT	LT	BILAT
<input type="checkbox"/> ARTERIAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> CAROTID DOPPLER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> SMALL PARTS / SOFT TISSUE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> UPPER EXTREMITY-NON VASCULAR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> LOWER EXTREMITY-VEIN DOPPLER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Based Upon This Patient's Symptoms & Diagnosis, I Have Requested The Above Procedure(s).

Provider Signature: _____ Date: _____
 Provider Name: _____ Phone: _____

MADERA

360 E. Almond Avenue • Madera, CA 93637



California Medical Imaging Associates is a sub-specialty radiology medical group dedicated to providing the highest level of diagnostic accuracy and personalized service to our partner hospitals, referring physicians and patients; quality, compliance, relationships and service above all else.

administrator@calrads.com • calrads.com