

Patient Name: _____ Date Ordered: _____ Phone # _____
First MI Last

Appointment
DATE:
TIME:

DOB: _____ Insurance Co.: _____
Diagnosis or reason for exam (please include ICD-9 codes) _____

Please fax insurance card and order. Thank you.

UPRIGHT/WEIGHT-BEARING



- BRAIN**
 Routine
 TMJ
 Orbits
 IAC's
 Pituitary
- MRA**
 Circle of Willis
 Carotid



- LOWER JOINTS**
 Hip
 Knee
 Ankle
 Foot
- L R
 L R
 L R
 L R

- UPPER JOINTS**
 Shoulder
 Elbow
 Wrist
 Hand
- L R
 L R
 L R
 L R

- MISCELLANEOUS (Recumbent Only)**
 Abdomen
 Pelvis
 Prostate
 Other _____

CERVICAL



Neutral Upright



Flexion Upright



Extension Upright



Lateral Bending Upright
 L R



Recumbent Comparison
 Standing

◆ Perform Recumbent Scan for Comparison? Yes No

LUMBOSACRAL



Neutral Upright



Flexion Upright



Extension Upright



Standing
 Lateral Bending Upright
 L R

◆ Perform Recumbent Scan for Comparison? Yes No ◆ Previous Lumbar Surgery? Yes No

Check whether exam is: No contrast With and Without Contrast
Radiologist's Discretion: Contrast Position Imaging

Physician's Name: _____ Phone: _____ Physician's Signature: _____

Copy of Films Phone Preliminary Report to: _____ Fax Preliminary Report to: _____
 CD of Images

Does patient have or ever had?

- ◆ Pacemaker? Yes No
- ◆ Any ear or eye implants? Yes No
- ◆ Pregnant? Yes No
- ◆ Previous Surgery? Yes No
- ◆ Body Piercing? Yes No
- ◆ Metal in body? Yes No
- ◆ Brain aneurysm clip? Yes No
- ◆ Allergies: _____