Patients Last Name:_____First Name: _____

DOB:_____Home #:_____Cell#: _____

Appointment Date:_____/_____/_____Time:_____M or F

Please arrive 30 minutes prior to exam

Diagnosis Code / Reason for Exam: _____

☐ SEND FILMS WITH PATIENT ☐ SEND CD WITH PATIENT

☐ FAX REPORT ☐ STAT CALL REPORT

FAX#:_____PH#:_____* Special instructions: _____

Referring Physician:_____Physician Signature: _____

BaylorScott&White MEDICAL CENTER UPTOWN
Joint ownership with physicians

2727 East Lemmon Avenue
Dallas, TX 75204
Phone: 214.443.3048
Fax: (214) 594-8481
Email:bmcuimaging@uspi.com

Please call PH# (214) 443-3048 to schedule an appointment.
Please fax this order form, patient demographics, and insurance cards to FAX# (214) 594-8481

*Based on screening of patients they may require a Creatinine * **LAB**: ☐ CREATININE

MRI

☐ **W/O IVcontrast** ☐ **W/ IVcontrast**
☐ **W/O & W/ IVcontrast**

ABDOMEN
☐ Abdomen
☐ Pelvis
☐ MRCP

HEAD/BRAIN
☐ Head
☐ Brain
☐ IAC – Sella – Pituitary
☐ Orbit – Face – Neck

CHEST
☐ Chest

SPINE
☐ Cervical
☐ Thoracic
☐ Lumbar

UPPER EXTREMITY JOINT
☐ Shoulder – Elbow – Wrist ☐ L ☐ R

UPPER EXTREMITY NON - JOINT
☐ Humerus – Forearm - Hand ☐ L ☐ R

LOWER EXTREMITY JOINT
☐ Hip – Knee - Ankle ☐ L ☐ R

LOWER EXTREMITY NON - JOINT
☐ Femur - Tib/Fib - Foot ☐ L ☐ R

☐ **Other MRI (Specify)**: _____

MRA
☐ Abdomen
☐ Head
☐ Neck
☐ Chest
☐ Upper Extremity
Specify:_____
☐ Upper Extremity
Specify:_____
☐ Pelvis
☐ **Other MRA (Specify)**: _____

CT

☐ **W/O IVcontrast** ☐ **W/ IVcontrast**
☐ **W/O & W/ IVcontrast**

ABDOMEN
☐ Abdomen/Pelvis
☐ Abdomen Only
☐ Pelvis Only
☐ Renal Stone Protocol

HEAD / BRAIN / NECK
☐ Head / Brain
☐ Facial – Orbits – Sinuses
☐ Soft Tissue Neck

CHEST
☐ Chest
☐ High Resolution

SPINE
☐ Cervical
☐ Thoracic
☐ Lumbar

UPPER EXTREMITY
☐ Shoulder ☐ L ☐ R
☐ Humerus ☐ L ☐ R
☐ Elbow ☐ L ☐ R
☐ Wrist ☐ L ☐ R
☐ Hand ☐ L ☐ R

LOWER EXTREMITY
☐ Hip ☐ L ☐ R
☐ Femur ☐ L ☐ R
☐ knee ☐ L ☐ R
☐ Lower Leg ☐ L ☐ R
☐ Ankle ☐ L ☐ R
☐ Foot ☐ L ☐ R
☐ **Other CT (Specify)**: _____

CTA
☐ Abdomen / Pelvis
☐ Abdomen Only
☐ Pelvis Only
☐ Head
☐ Neck
☐ Chest PE
☐ Extremity: _____
☐ **Other CTA (Specify)**: _____

X-RAY

HEAD
☐ Skull Complete ☐ Skull Limited 2 View
☐ Facial Bones Complete ☐ Sinuses
☐ Mandible ☐ Orbits
☐ Nasal series

ABDOMEN
☐ Abd 1View (KUB)
☐ Abd 2 View (Flat & Upright)
☐ Abd Acute Series (Flat,Upright & PA Chest)

CHEST
☐ PA & Lat Routine 2 view
☐ PA or AP 1View
☐ Rib Series w/PA Chest ☐ L ☐ R

SPINE
☐ Cervical Spine 2-3 View
☐ Cervical Complete Min 4 View (W/Obliques)
☐ Cervical Complete Min 4 View (W/Flex & Ext)
☐ Thoracic Spine 2-3 View
☐ Thoraco-Lumbar Spine
☐ Lumbar Spine 2-3 View
☐ Lumbar Complete Min 4 View (W/Obliques)
☐ Lumbar Complete Min 4 View (W/Flex & Ext)
☐ Sacrum and Coccyx

PELVIS
☐ Pelvis 1view
☐ Pelvis 3vw (Specify): _____
☐ Hips ☐ L ☐ R
☐ SI Joints

UPPER EXTREMITIES
☐ Shoulder ☐ L ☐ R
☐ Clavicle ☐ L ☐ R
☐ Humerus ☐ L ☐ R
☐ Elbow ☐ L ☐ R
☐ Forearm ☐ L ☐ R
☐ Wrist ☐ L ☐ R
☐ Hand ☐ L ☐ R
☐ Finger (Specify): _____ ☐ L ☐ R

LOWER EXTREMITIES
☐ Hip ☐ L ☐ R
☐ Femur ☐ L ☐ R
☐ Knee ☐ L ☐ R
☐ Tib/Fib ☐ L ☐ R
☐ Ankle ☐ L ☐ R
☐ Calcaneous (Heel) ☐ L ☐ R
☐ Foot ☐ L ☐ R
☐ Toes (Specify): _____ ☐ L ☐ R

☐ **ARTHROGRAM (Specify joint and side)**:
_____

ULTRASOUND

US ABDOMEN
☐ Head
☐ Soft Tissue Neck
☐ Thyroid
☐ Abdomen Complete
☐ Abdomen Limited (Specify) _____
☐ Gallbladder
☐ Aorta ☐ Renal
☐ Pelvic ☐ Pelvic With Transvaginal ☐ Transvaginal only
☐ Testicular
☐ **Other SONO (Specify)**: _____

DOPPLER
☐ Venous Upper Ext ☐ L ☐ R
☐ Venous Lower Ext ☐ L ☐ R
☐ Arterial Upper Ext ☐ L ☐ R Specify _____
☐ Arterial Lower Ext ☐ L ☐ R Specify:_____
☐ Carotid
☐ **Other (Specify)**: _____