San Fernando Valley Centers Imaging Request

RADNET MANAGEMENT, INC.

☐ San Fernando Interventional Radiology & Imaging Center
☐ Liberty Pacific Advanced Imaging ☐ San Fernando Advanced MRI
☐ Santa Clarita Imaging Center ☐ Santa Clarita X-Ray
☐ Northridge Diagnostic Center ☐ Burbank Advanced Imaging
☐ Northridge Diagnostic Center/*Satellite* ☐ The Encino Breast Care Center
☐ Vanowen Advanced Imaging

Appointment Date:_____ **Appointment Time:**_____ **Today's Date:**_____

Patient's Name:_____ **Date of Birth:**_____

Clinical History/Reason for Exam:_____

Insurance Information:_____ **Patient's Phone:**_____

Referring Physician:_____ **Physician Signature:**_____

Phone:_____ **Auth #:**_____ ☐ **Patient to bring images to Doctor** ☐ **Call in STAT results**

MR

MRI
☐ **With & Without Contrast**
☐ **Without Contrast**
☐ **Contrast, as Indicated**
☐ Brain
☐ w/special attention to IAC
☐ w/special attention to Pituitary
☐ Orbits
☐ TMJ
☐ Neck - Soft Tissue
☐ Spine:
___Cervical__Thoracic__Lumbar
☐ Extremity: Joint __Left __Right
Specify body part_____
☐ Extremity: Non-Joint __Left __Right
Specify body part_____
☐ Breast ___CAD
___Mass__Implant
☐ MR Guided Breast Biopsy
☐ Chest
☐ Abdomen
___Adrenals ___MRCP
☐ Pelvis __Bony Pelvis __Soft Tissue
☐ Spectroscopy - Brain
☐ CSF Flow Study
☐ Other:_____

MR Angiography
☐ **With & Without Contrast**
☐ **Without Contrast**
☐ **Contrast, as Indicated**
☐ Brain
☐ Neck - Carotids
☐ Chest
☐ Abdomen
___Aorta ___Renal
☐ Aorta and runoff vessels
☐ Pelvis
☐ Extremity: __Left __Right
☐ Other:_____

MR Arthrography **__Left __Right**
☐ Shoulder
☐ Elbow
☐ Wrist
☐ Hip
☐ Knee
☐ Ankle
☐ Other:_____

CT

Diagnostic CT
☐ **With & Without Contrast**
☐ **Without Contrast**
☐ **Contrast, as Indicated**
☐ Brain
☐ Orbits
☐ IAC Middle Ear
☐ Maxillofacial - Facial Bones
___ Bones ___Implants
☐ Sinus (Maxillofacial)
☐ Neck (soft tissue)
☐ Spine:
__Cervical __Thoracic __Lumbar
☐ Extremity __Left __Right
Specify body part_____
☐ Chest
☐ Abdomen (pelvis if indicated)
☐ Abdomen and Pelvis
☐ Urogram (abdomen/pelvis)
☐ Pelvis
☐ Treatment Plan:_____
☐ Dental Planning
☐ Biopsy_____
☐ Other:_____

CTA (angiography)
☐ Head
☐ Neck
☐ Extremity: __Upper __Lower
☐ Chest
☐ Aorta and runoff vessels
☐ Abdomen
☐ Pelvis
☐ Cardiac
__Coronary__Calcium Score__EP Plan

Creatinine:_____
Lab Date:_____

Breast Imaging

☐ Screening Mammogram
☐ Diagnostic Mammogram
Breast Ultrasound (if indicated)
__Unilateral __Bilateral
☐ Breast Ultrasound
__Left __Right __Bilateral
☐ Stereotactic Breast Biopsy
☐ Other_____

Date last mammogram:_____

Breast implants: ___Yes ___No

Ultrasound

☐ Abdomen_____
☐ Abdomen Limited
__Liver__Gallbladder
__Right Upper Quadrant
☐ Abdomen w/Doppler if indicated
☐ Renal_____
☐ w/bladder
☐ Bladder_____
☐ Aorta/Retroperitoneal
☐ Pelvis (TV if indicated)
☐ Pelvis Transabdominal Only
☐ Scrotum ___w/Doppler
☐ Thyroid_____
☐ Biopsy / Aspiration / Injection
Area_____
☐ Other_____

Vascular Studies
☐ Arterial Doppler (Duplex)_____
☐ Carotid Doppler (Duplex)_____
☐ Venous Doppler (Duplex)_____
☐ Extremity
__Upper __Lower __L __R __Bil
☐ Other_____

OB Ultrasound
☐ OB Ultrasound (TV if indicated)_
☐ Limited (Viability, Heart Beat, Position, Fluid, Placental Location)_____
☐ Follow-up -- specify documented problem_____

Fluoroscopy

☐ Arthrography
Specify body part_____
☐ IVP
☐ Esophagram
☐ Hysterosalpingogram (HSG)
☐ UGI
☐ UGI w/SBFT
☐ Small Bowel
☐ Barium Enema
☐ Other:_____

DEXA

☐ Bone Density
Reason for bone density:_____
_____
Date of last exam:_____

PET/CT

☐ PET/CT, Skull Base to Mid-Thigh
☐ PET/CT, Whole Body (Melanoma)
☐ PET/CT, Brain
☐ PET/CT, Cardiac
__Viability - FDG
__Myocardial Perfusion--Rubidium

Nuclear Medicine

☐ Bone Scan_____
__Whole Body __Limited __3-phase
☐ Bone SPECT
☐ Thyroid Scan
☐ Thyroid Uptake and Scan
☐ Parathyroid
☐ Myocardial Perfusion (heart)
__Exercise __Pharmacologic
☐ MUGA (cardiac blood pool)
☐ Liver/Spleen
☐ Gallbladder (HIDA) with CCK
☐ Gallbladder without CCK
☐ GI Emptying
☐ GI Bleed
☐ Meckels
☐ Renal __Captopril __Lasix
☐ Gallium
☐ White Blood Cell (WBC)
☐ Other_____

X-Ray

☐ Head:
__skull__orbits__sinuses
☐ Spine:
__cervical__thoracic__lumbar
☐ Chest: __PA ____PA/LAT
☐ Ribs:
__Unilateral__Bilateral __w/PA Chest
☐ Abdomen: __KUB __Two Views
☐ Pelvis
☐ Hips w/AP pelvis, bilateral
__Unilateral __Left __Right
☐ Extremity:
__Left __Right __Bilateral
Specify Body Part_____
☐ Other:_____
_____

Interventional Radiology

For Services please call
818-817-7707

Please bring this form and your insurance card with you on the day of your exam.