MCI DIAGNOSTIC CENTER
Redefining Your Diagnostic Imaging

Diagnostic Referral Request

Patient Name:_____ Date of Birth: ____/____/____ Date: ____/____/____

Patient Address:_____ City:_____ Zip Code:_____

Patient Phone #:_____ Work/Cell:_____ E-Mail:_____

Insurance Co.:_____ Policy No.:_____ Office Contact:_____

Physician Signature_____ Physician Phone #:_____ Physician Fax #:_____

DIAGNOSIS:_____

COMMENTS: _____

MCI Diagnostic Center will contact the patient and set up appointment.

Please fax this form along with a copy of the Patient's Insurance Card.

CT SCAN

Table Limit: 450 lbs.

Please Check: ☐ ***W/Contrast*** ☐ ***W/O Contrast***

- ☐ CT Head
- ☐ CT Sinuses
- ☐ CT Chest
- ☐ CT Abdomen
- ☐ CT Pelvis
- ☐ CT Spine ☐ Cervical ☐ Thoracic ☐ Lumbar
- ☐ CT Extremity Upper / Lower ☐ R ☐ L
- ☐ CT Calcium Score
- ☐ CTA of _____
- ☐ CT Other _____

HOLTER MONITORING

- ☐ 24-Hour Holter Monitor
- ☐ 30-Day Event Monitor

BONE DENSITY (DEXA)

Table Limit: 500 lbs.

- ☐ Bone Density Scan (DEXA)

CARDIAC STRESS TESTING

- ☐ MPS Stress Test
  - ☐ **Exercise OR** ☐ **Chemical**
- ☐ EKG

SLEEP LAB

- ☐ Polysomnogram (PSG) Test
- ☐ Split Night Test
- ☐ PSG/Titration (2-Night)

X-RAY

Table Limit: 400 lbs.

- ☐ Abdomen (KUB)
- ☐ Chest
- ☐ Spine ☐ C ☐ T ☐ L
- ☐ Shoulder ☐ R ☐ L ☐ Bilat.
- ☐ Elbow ☐ R ☐ L ☐ Bilat.
- ☐ Wrist ☐ R ☐ L ☐ Bilat.
- ☐ Hip ☐ R ☐ L ☐ Bilat.
- ☐ Knee ☐ R ☐ L ☐ Bilat.
- ☐ Ankle ☐ R ☐ L ☐ Bilat.
- ☐ Other _____

MRI HIGH FIELD

Table Limit: 550 lbs.

Please Check: ☐ ***W/Contrast*** ☐ ***W/O Contrast***

- ☐ MRI Brain
- ☐ MRI IAC's
- ☐ MRI Pituitary
- ☐ MRI Orbits
- ☐ MRI Soft Tissue Neck
- ☐ MRI Spine ☐ Cervical ☐ Thoracic ☐ Lumbar
- ☐ MRI Kidney
- ☐ MRI Abdomen
- ☐ MRI Pelvis
- ☐ MRI Knee ☐ L ☐ R
- ☐ MRI Ankle ☐ L ☐ R
- ☐ MRI Foot ☐ L ☐ R
- ☐ MRI Shoulder ☐ L ☐ R
- ☐ MRI Elbow ☐ L ☐ R
- ☐ MRI Wrist ☐ L ☐ R
- ☐ MRI Hand ☐ L ☐ R
- ☐ MRA Brain
- ☐ MRA Carotid
- ☐ Other _____

FLUOROSCOPY

- ☐ Epidural Steroid Injection
  - ☐ Cervical ☐ Thoracic ☐ Lumbar
- ☐ Joint Injection
  - Location: _____
- ☐ Arthrogram
  - Location: _____
  - ☐ MRI
  - ☐ CT
- ☐ Myelogram
  - Location _____
- ☐ Discogram-
  - Level(s) _____

NUCLEAR MEDICINE

Table Limit: 450 lbs.

- ☐ Bone Scan Whole Body
- ☐ Bone Scan Limited
- ☐ Bone Scan 3-Phase
- ☐ Bone SPECT
- ☐ Gastric Emptying
- ☐ HIDA Scan w/ CCK
- ☐ Indium Scan
- ☐ MUGA Scan
- ☐ Parathyroid Scan
- ☐ Thyroid Uptake & Scan
- ☐ Other _____

ULTRASOUND GENERAL

- ☐ US Breast ☐ L ☐ R
- ☐ US OB (TV if needed)
  - ***Est. Due Date:*** _____
- ☐ US Pelvis (TV if needed)
- ☐ US Transvaginal
- ☐ US Abdomen
- ☐ US Liver / Gallbladder
- ☐ US Renal
- ☐ US Scrotum
- ☐ US S.T. Neck
- ☐ US Thyroid
- ☐ US Other _____

ULTRASOUND CARDIOVASCULAR

- ☐ ABI ☐ L ☐ R
- ☐ Arterial Doppler ☐ L ☐ R
- ☐ Venous Doppler ☐ L ☐ R
- ☐ Carotiod Doppler
- ☐ Stress Echo
- ☐ Echo

PLEASE FAX REFERRAL TO: 918.744.9729

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Fully accredited by the Joint Commission (JCAHO)