

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 _____

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 _____

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 _____

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 _____

FLUOROSCOPY

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

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
- Carotid Doppler
- Stress Echo
- Echo



PLEASE FAX REFERRAL TO: 918.744.9729

7018 S. Utica Ave. Tulsa, OK. 74136 | Phone: 918-744-1001 | Fax: 918-744-9729

Fully accredited by the Joint Commission (JCAHO)