



**SCHEDULING:**  
PHONE: 915-333-7010  
FAX: 915-855-6404

☐ **STAT REPORT**  
☐ **PROVIDE CD/DISC**

## PATIENT INFORMATION

Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Primary Phone: \_\_\_\_\_ Sex: ☐ M ☐ F  
Date of Injury: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Auto: ☐ Yes ☐ No LOP: ☐ Yes ☐ No Worker's Comp ☐ Yes ☐ No  
Attorney Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
☐ **STAT** ☐ **CONTRAST** ☐ **W/O CONTRAST**

## MRI

- |  |  |
|--|--|
| <input type="checkbox"/> Cervical<br><input type="checkbox"/> Alar Ligaments<br><input type="checkbox"/> Flex/Ext  | <input type="checkbox"/> Pelvis<br><input type="checkbox"/> Shoulder L R<br><input type="checkbox"/> Humerus L R<br><input type="checkbox"/> Elbow L R<br><input type="checkbox"/> Forearm L R<br><input type="checkbox"/> Wrist L R<br><input type="checkbox"/> Hand/Finger L R<br><input type="checkbox"/> Hip L R<br><input type="checkbox"/> Femur L R<br><input type="checkbox"/> Knee L R<br><input type="checkbox"/> Tib/Fib L R<br><input type="checkbox"/> Ankle L R<br><input type="checkbox"/> Foot/Toes L R<br><input type="checkbox"/> <b>With/Without Contrast</b><br><input type="checkbox"/> Other _____<br><input type="checkbox"/> <b>Claustrophobic</b> |
| <input type="checkbox"/> Thoracic<br><input type="checkbox"/> Lumbar<br><input type="checkbox"/> MRA Brain<br><input type="checkbox"/> MRA Carotids<br><input type="checkbox"/> Brain<br><input type="checkbox"/> DTI<br><input type="checkbox"/> NeuroQuant/Icobrain<br><input type="checkbox"/> Pituitary<br><input type="checkbox"/> ICA's<br><input type="checkbox"/> Chest<br><input type="checkbox"/> Brachial Plexus<br><input type="checkbox"/> Abdomen<br><input type="checkbox"/> <b>Implanted Metal</b><br><input type="checkbox"/> <b>Pace Maker</b> |  |

## X-RAYS

- |  |  |
|--|--|
| <input type="checkbox"/> Cervical<br><input type="checkbox"/> AP/Lat<br><input type="checkbox"/> Odontoid Series<br><input type="checkbox"/> Obliques<br><input type="checkbox"/> Flex/Ext<br><input type="checkbox"/> Thoracic<br><input type="checkbox"/> Lumbar<br><input type="checkbox"/> AP/Lat<br><input type="checkbox"/> Obliques<br><input type="checkbox"/> Flex/Ext<br><input type="checkbox"/> Skull<br><input type="checkbox"/> Nasal Bones<br><input type="checkbox"/> Orbits<br><input type="checkbox"/> Facial Bones<br><input type="checkbox"/> Sinus<br><input type="checkbox"/> Chest PA Only<br><input type="checkbox"/> Chest 2 Views<br><input type="checkbox"/> Ribs L R | <input type="checkbox"/> Soft Tissue Neck<br><input type="checkbox"/> Pelvis<br><input type="checkbox"/> Sacrum/Coccyx<br><input type="checkbox"/> SI Joints<br><input type="checkbox"/> Shoulder L R<br><input type="checkbox"/> Humerus L R<br><input type="checkbox"/> Elbow L R<br><input type="checkbox"/> Forearm L R<br><input type="checkbox"/> Wrist L R<br><input type="checkbox"/> Hand/Finger L R<br><input type="checkbox"/> Hip L R<br><input type="checkbox"/> Femur L R<br><input type="checkbox"/> Knee L R<br><input type="checkbox"/> Tib/Fib L R<br><input type="checkbox"/> Ankle L R<br><input type="checkbox"/> Foot/Toes L R<br><input type="checkbox"/> Other _____ |
|--|--|

## COMPUTED TOMOGRAPHY-CT

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> CT Head<br><input type="checkbox"/> CT Facial Bones<br><input type="checkbox"/> CT Abdomen<br><input type="checkbox"/> CT Pelvis | <input type="checkbox"/> CT C-Spine<br><input type="checkbox"/> CT T-Spine<br><input type="checkbox"/> CT L-Spine<br><input type="checkbox"/> CT Other | <input type="checkbox"/> CT Lower Extremity<br><input type="checkbox"/> Right <input type="checkbox"/> Left<br>Area: _____ | <input type="checkbox"/> CT Upper Extremity<br><input type="checkbox"/> Right <input type="checkbox"/> Left<br>Area: _____ |
|---|--|--|--|

## PHYSICIAN INFORMATION

Referring Physician: \_\_\_\_\_ Clinic: \_\_\_\_\_  
Referring Physician's Phone: \_\_\_\_\_ Fax report to: \_\_\_\_\_

*\*ICD-10 and complete corresponding description and separate code for each test ordered. \*Please do not use "rule out" or "Possible/Probable"*

### COMMONLY USED ICD 10 CODES & DESCRIPTIONS

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> S06.2 Traumatic Brain Injury  | <input type="checkbox"/> S06.2XOA DTI Injury w/o loss of concussion | <input type="checkbox"/> R41.2Retrograde Amnesia          |
| <input type="checkbox"/> M54.12 Cervical Radiculopathy | <input type="checkbox"/> M54.16 Lumbar Radiculopathy                | <input type="checkbox"/> G31.84 Mild Cognitive Impairment |
| <input type="checkbox"/> M54.5 Low Back Pain           | <input type="checkbox"/> M25.552 Left Hip Pain                      | <input type="checkbox"/> M25.551 Right Hip Pain           |

# Patient Preparations for Procedures

## CT Exam (CAT SCAN) Preparations

**ABDOMINAL & PELVIS:** Can have clear liquids and all medications are permitted up to four hours prior to the exam. Patient will need to drink barium liquid at specific time. Barium liquid will taste best cold or may be mixed with orange juice.

**Specific instructions as follows:**

**ABDOMEN ONLY:** Drink one bottle of barium liquid one hour prior to exam time.

**ABDOMINAL & PELVIS:** Drink one bottle of barium liquid two hours prior and one bottle one hour prior to exam.

**PELVIS ONLY:** Drink one bottle one hour before exam.

**BRAIN W/ CONTRAST, SOFT TISSUE, NECK, SOFT TISSUE ORBITS, CHEST:** Can have clear liquids and all medications are permitted up to four hours prior to exam.

**CHEST CT:** Send most recent chest x-ray and report with patient as this will **expedited** reading. Chest x-ray will be taken if indicated.

**FOR CONTRAST STUDIES ONLY:** If patient is diabetic, 60 years of age or older, the results of a BUN/Creatine blood test performed no more than 30 days prior to CT Exam must be faxed to center. This must be within normal limits to perform the test.

## MRI (Magnetic Resonance Imaging) Preparation

**No Jewelry**

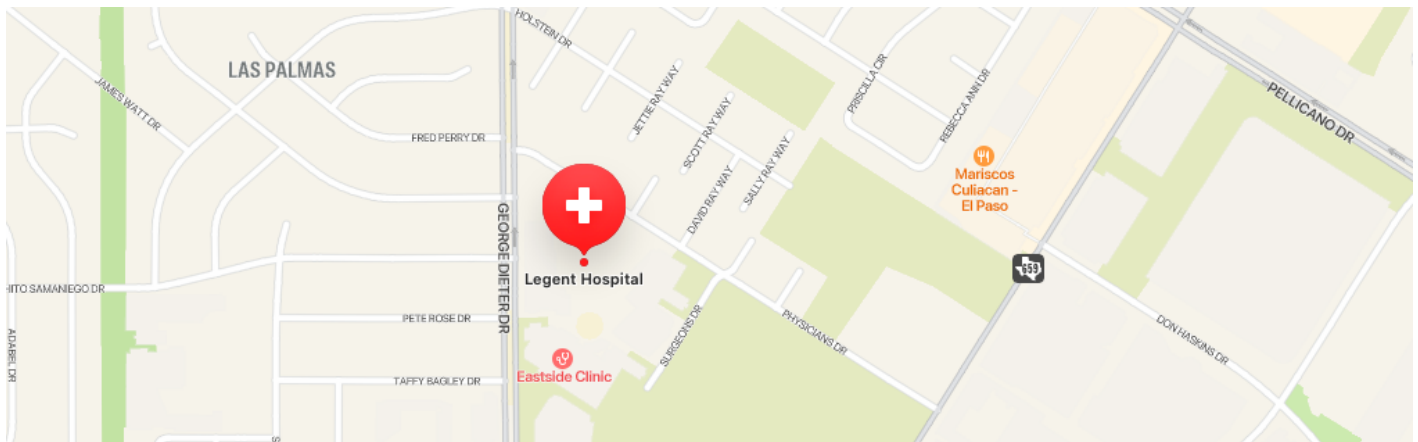
**No Hairpins**

**No Pacemaker**

No preparation needed. Arrive 30 minutes prior to scheduled appointment.

Wear simple clothing.

***The above preparations are only recommendations by our radiologists. Other preps may be followed.***



**1416 George Dieter Dr. El Paso, TX 79936**