



Appt. Date and Time _____
 Patient Contact # _____
 Authorization # _____

APPOINTMENT SCHEDULING
 708-381-5422 phone
 708-381-5429 fax

ADDRESS INFORMATION:

18660 Graphics Dr.
 Suite 101
 Tinley Park, IL 60477



Patient _____ DOB _____

Male Female

Diagnosis _____

Routine Stat

Referring Physician (Please Print) _____

Referring Physician Signature _____

Physician Office Phone Number _____

For MRI / CT with contrast: BUN results: _____ Creatinine results: _____

MRI CT

Ankle (Ankle, Rearfoot, Midfoot)
 Right Left

Forefoot (Forefoot, Midfoot)
 Right Left

Entire Foot (Forefoot, Midfoot, Digits)
 Right Left

DIAGNOSIS

_____ tendon pathology

Fracture or contusion

Heel Pain

Ligament injury

Mass (ganglion, neuroma, etc.)

Osteomyelitis

Plantar fibromatosis

Talar dome lesion

Tarsal coalition

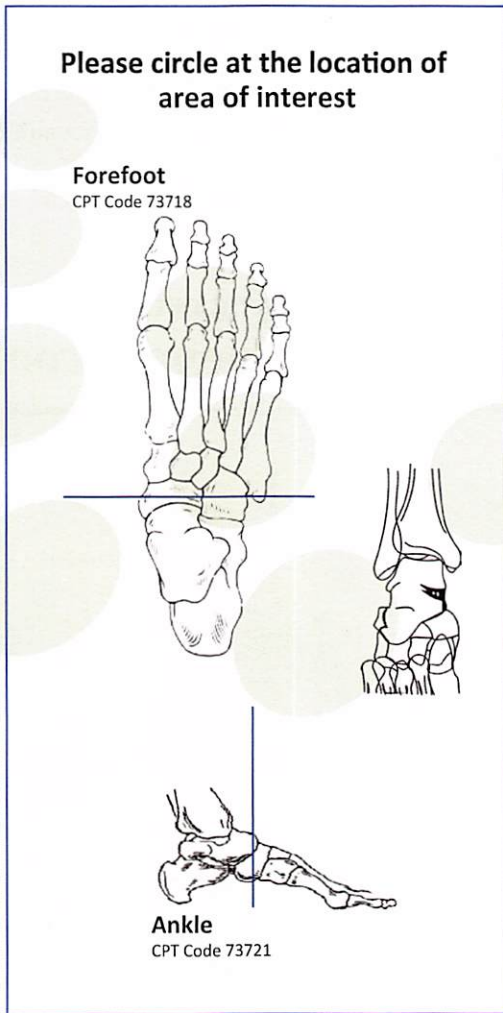
Tarsal tunnel

Other _____

Contrast

Contrast at the discretion of Radiologist

History of renal disease



ULTRASOUND

Specify: _____

Specify: _____

Specify: _____

X-RAY

Specify: _____

Specify: _____

Specify: _____

OTHER

Specify: _____

Specify: _____

Specify: _____

Phone Stat Report Fax Report Dr. Baron, D.P.M. Reading M.D. Reading



APPOINTMENT SCHEDULING

708-381-5422 phone

708-381-5429 fax

MRI Prep Instructions

Your comfort during the procedure is one of our highest priorities. We can achieve it through your help with the following:

- Please arrive 15 minutes ahead of time to complete any necessary paperwork
- Please remember to bring a picture ID, your insurance card, and the referral form
- Please wear comfortable, loose-fitting clothing. Avoid underwire bras, girdles, metal snaps and pins.
- You may eat and drink normally prior to your MRI procedure
- All medications should be taken as prescribed.

CT Prep Instructions

Some CT Procedures require oral contrast, IV Injection and fasting. Ask your Physician if there is any preparation required. Please bring any previous MRI, CT or X-ray films and / or reports.

If there is any possibility that you might be pregnant, please notify your physician and our staff.

Ultrasound Prep Instructions

Fasting Prep - The patient is not to drink or eat anything by mouth for at least 6-8 hours prior to the following Ultrasound Exams:
Aorta, Abdomen Complete, Liver / Gallbladder / Pancreas, Various Pelvic Exams

Full Bladder Prep - The patient should drink 32 oz of water one hour prior to the test. Do not go to the bathroom before your test.

You must have a full bladder when you come to your appointment. The following Ultrasound Exams that require a full bladder prep are:
Pelvic Ultrasound

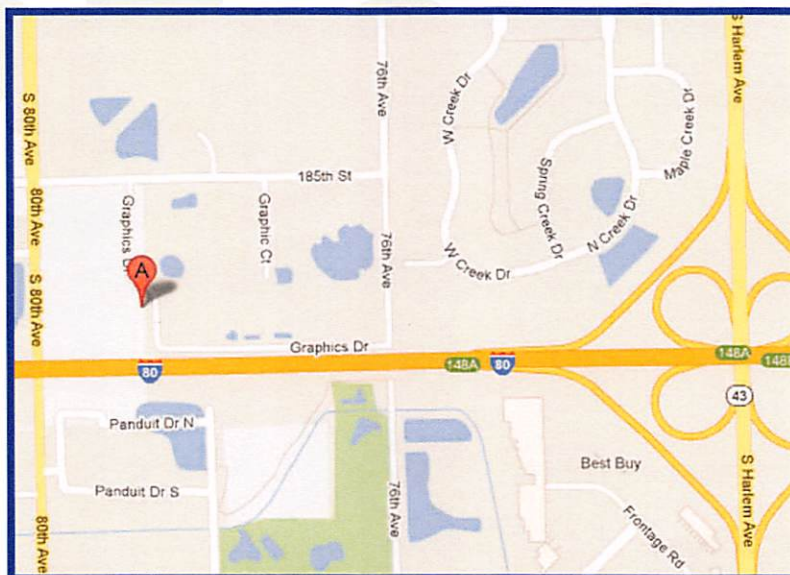
Light Meal - May be eaten prior to scanning by diabetic and pregnant patients

Medication - All medication should be taken as prescribed

For detailed directions to each imaging center please visit our website at:

tinleyparkopenmri.com

**Tinley Park
Open MRI & CT**
18660 Graphics Drive,
Suite 101,
Tinley Park



Directions

From the North/ South/ East: Take Harlem to 183rd Street and go West toward 80th Avenue. Go South on 80th Avenue to 185th Street. Make a left onto 185th Street. Make a right onto Graphics Drive and go straight South to the building.

From the West/ Southwest: Take LaGrange Road to 191st Street, and go East toward 80th Avenue. Go North on 80th Avenue (over I-80 bridge) and then make a right onto 185th Street. Make a right onto Graphics Drive and go straight South to the building.



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Indications _____

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High Field MRI

Ultrasound

Xray

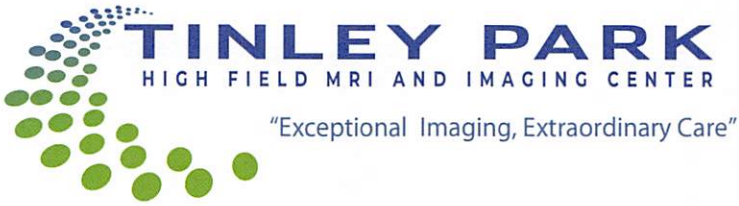
CT

MRI	
<input type="checkbox"/> W GAD	<input type="checkbox"/> W/WO GAD
<input type="checkbox"/> Abdomen/Kidneys/Liver	<input type="checkbox"/> WO
<input type="checkbox"/> Ankle	R L
<input type="checkbox"/> Brachial Plexus	R L
<input type="checkbox"/> Cervical Spine	
<input type="checkbox"/> Chest	
<input type="checkbox"/> Elbow	R L
<input type="checkbox"/> Enterography	
<input type="checkbox"/> Foot	R L
<input type="checkbox"/> Hand	R L
<input type="checkbox"/> Head/Brain	
<input type="checkbox"/> Hips	R L
<input type="checkbox"/> IACs	
<input type="checkbox"/> Knee	R L
<input type="checkbox"/> Lumbosacral Spine	
<input type="checkbox"/> MRCP	
<input type="checkbox"/> Orbit/Face/Sinus	
<input type="checkbox"/> Pelvis	
<input type="checkbox"/> Pituitary	
<input type="checkbox"/> Sacrum/SI Joints	
<input type="checkbox"/> Shoulder	R L
<input type="checkbox"/> Soft Tissue Neck	
<input type="checkbox"/> Thoracic Spine	
<input type="checkbox"/> TMJ	
<input type="checkbox"/> Wrist	R L
<input type="checkbox"/> Other:	_____
MR ANGIOGRAPHY	
<input type="checkbox"/> Head: ___ Arterial ___ Venous	
<input type="checkbox"/> Neck	
<input type="checkbox"/> Other:	_____
MR ARTHROGRAM	
<input type="checkbox"/> Joint _____	R L

CT	
<input type="checkbox"/> W	<input type="checkbox"/> W/WO
<input type="checkbox"/> WO	<input type="checkbox"/> PO Only
<input type="checkbox"/> 3D Specify Part:	_____
<input type="checkbox"/> Abdomen Only	
<input type="checkbox"/> Abdomen and Pelvis:	
<input type="checkbox"/> Bony Pelvis	
<input type="checkbox"/> Brain/Head	
<input type="checkbox"/> Cervical Spine	
<input type="checkbox"/> Chest: ___ Low Dose (Lung CA Screening)	
___ Routine ___ High Res ___ PE	
<input type="checkbox"/> Enterography	
<input type="checkbox"/> Extremity:	_____
<input type="checkbox"/> Facial Bones/Jaw	
<input type="checkbox"/> Hip	R L
<input type="checkbox"/> Lumbosacral Spine	
<input type="checkbox"/> Orbits	
<input type="checkbox"/> Pelvis Only	
<input type="checkbox"/> Sinuses: ___ Routine ___ Stryker	
<input type="checkbox"/> Soft Tissue Neck	
<input type="checkbox"/> Temporal Bones/Mastoids/IACs	
<input type="checkbox"/> Thoracic Spine	
<input type="checkbox"/> Urogram wo/w	
<input type="checkbox"/> Other:	_____
CT ANGIOGRAPHY INCLUDING 3D	
<input type="checkbox"/> Abdomen/Pelvis	
<input type="checkbox"/> Chest	
<input type="checkbox"/> Head	
<input type="checkbox"/> Neck	
<input type="checkbox"/> Other:	_____

ULTRASOUND	
<input type="checkbox"/> 2D Echo Cardiogram	
<input type="checkbox"/> Abdomen	
<input type="checkbox"/> Aorta	
<input type="checkbox"/> Arterial: Leg: R L Both	
Arm: R L Both	
<input type="checkbox"/> Bladder	
<input type="checkbox"/> Breast R L Both	
<input type="checkbox"/> Carotid	
<input type="checkbox"/> OB Complete	
<input type="checkbox"/> OB + Biophysical Profile	
<input type="checkbox"/> Pelvis	
<input type="checkbox"/> Prostate	
<input type="checkbox"/> Renal	
<input type="checkbox"/> Scrotum/Testicles	
<input type="checkbox"/> TA Only	
<input type="checkbox"/> TA + TV	
<input type="checkbox"/> Thyroid	
<input type="checkbox"/> Venous: Leg: R L Both	
Arm: R L Both	
<input type="checkbox"/> Other:	_____
<input type="checkbox"/> Other:	_____
X-RAYS	
<input type="checkbox"/> Specify:	_____
<input type="checkbox"/> Specify:	_____
<input type="checkbox"/> Specify:	_____

Phone Stat Report Fax Report Radiologist Reading Radiology D.C. Reading
 Dr. Douglas Gregerson



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Pelvic Ultrasound, Bladder, OB 1st trimester, Prostate

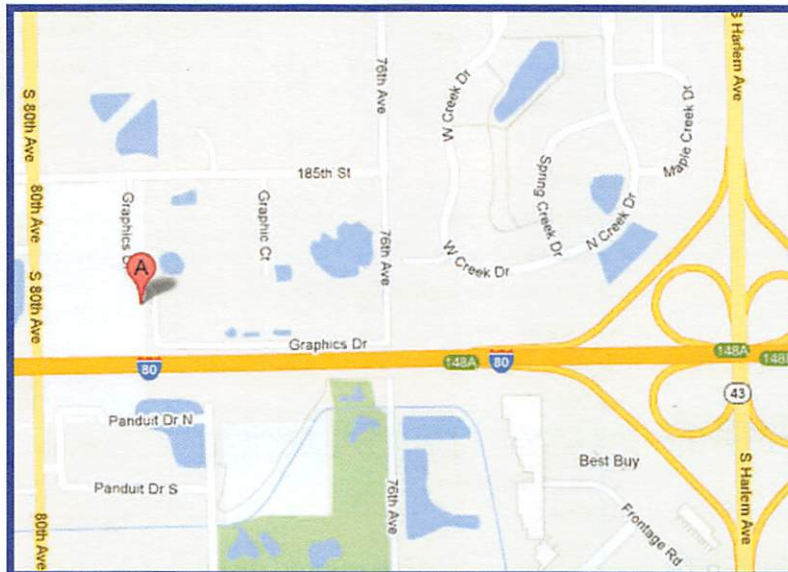
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Tinley Park Open MRI and Imaging Center

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