



DALLAS DIAGNOSTIC IMAGING SERVICES

SE HABLA ESPANOL

214-337-6513 • Fax: 214-988-1000

8355 WALNUT HILL LANE, # 200A, DALLAS, TEXAS, 75231

REFERRAL DATE: _____

Patient's Name: _____ D.O.B.: _____

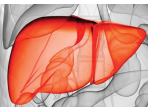
Phone: _____ Diagnosis: _____

Please assist in authorization (fax order, patient demographics, insurance card, and clinical notes pertaining to exam.)

Referring Physicians Signature Required Below

Referring Dr. Signature: _____ **Referring Office Contact:** _____

Office Phone: _____ **Office Fax:** _____

MRI	1.5T High Field TGC15302(10009435)	<input type="checkbox"/> Abdomen <input type="checkbox"/> Chest <input type="checkbox"/> MRCP <input type="checkbox"/> Pelvis <input type="checkbox"/> Shoulder <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Hip <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Hand <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Wrist <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Elbow <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Knee <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Ankle <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Foot <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Extremity _____ <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> MRAngiogram Head <input type="checkbox"/> MRAngiogram Neck <input type="checkbox"/> MRAngiogram Renal <input type="checkbox"/> Prostate <input type="checkbox"/> Other _____
	<input type="checkbox"/> With/Without Contrast <input type="checkbox"/> Without Contrast <input type="checkbox"/> Research Study PDFF <input type="checkbox"/> Brain <input type="checkbox"/> Pituitary <input type="checkbox"/> Internal Auditory Canals <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Sacrum <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Orbits	<input type="checkbox"/> OB Less Than 14 Weeks <input type="checkbox"/> Prostate <input type="checkbox"/> Pelvic <input type="checkbox"/> Renal <input type="checkbox"/> Renal w/ Doppler <input type="checkbox"/> US Breast <input type="checkbox"/> UNILATERAL <input type="checkbox"/> BILATERAL <input type="checkbox"/> Soft Tissue _____	<input type="checkbox"/> Testicular/Scrotal <input type="checkbox"/> w/Doppler <input type="checkbox"/> Thyroid <input type="checkbox"/> Transvaginal only VENOUS/ARTERIOA DOPPLER (Circle One or Both) <input type="checkbox"/> Lower Extremity <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> BILAT <input type="checkbox"/> Upper Extremity <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> BILAT <input type="checkbox"/> Other _____
	<input type="checkbox"/> TGC15302(10009435) _____ <input type="checkbox"/> Facial Bones <input type="checkbox"/> Sinuses <input type="checkbox"/> Chest PA & Lateral <input type="checkbox"/> Ribs (specify) <input type="checkbox"/> Bilateral <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Cervical Spine 2v, 4v, 6 view <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine 2v, 4v, 6 View	<input type="checkbox"/> KUB <input type="checkbox"/> Abdomen Series <input type="checkbox"/> Pelvis AP <input type="checkbox"/> Hip <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Femur <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Knee <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Tibia/Fibula <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Ankle <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Foot <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Skull Complete <input type="checkbox"/> Shoulder <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Humerus <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Elbow <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Forearm <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Wrist <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Hand <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Finger (specify) _____ <input type="checkbox"/> Other _____
	 <input type="checkbox"/> Routine Exam <input type="checkbox"/> Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> Non-Alcoholic Fatty Liver Disease (NAFLD) <input type="checkbox"/> Non-Alcoholic Steatohepatitis (NASH) <input type="checkbox"/> Alcoholic Liver Disease (ALD) <input type="checkbox"/> Other _____	
DEXA	<input type="checkbox"/> LUNAR iDEXA2 ___ Adult Dexa ___ Pediatric Dexa ___ Body Composition ___ Research Subject Bone and Metabolic Health		