DALLAS DIAGNOSTIC IMAGING SERVICES

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

☐ **With/Without Contrast** ☐ **Without Contrast**

- ☐ Brain
- ☐ Orbits
- ☐ Pituitary
- ☐ Internal Auditory Canals
- ☐ Cervical ☐ Thoracic ☐ Lumbar ☐ Sacrum
- ☐ Soft Tissue Neck
- ☐ TMJ
- ☐ Abdomen
- ☐ Chest
- ☐ MRCP
- ☐ Pelvis
- ☐ Shoulder ☐ R ☐ L
- ☐ Hip ☐ R ☐ L
- ☐ Hand ☐ R ☐ L
- ☐ Wrist ☐ R ☐ L
- ☐ Elbow ☐ R ☐ L
- ☐ Knee ☐ R ☐ L
- ☐ Ankle hind foot ☐ R ☐ L
- ☐ Foot fore/mid ☐ R ☐ L
- ☐ Extremity_____ ☐ R ☐ L
- ☐ MRAngiogram Head
- ☐ MRAngiogram Neck
- ☐ MRAngiogram Renal
- ☐ Prostate
- ☐ Other _____

ULTRASOUND

- ☐ Abdomen Complete (NPO)
- ☐ Abdomen Doppler Complete (NPO)
- ☐ Abdomen Limited (NPO)
- ☐ Aorta (NPO) ☐ Aorta w/ Doppler
- ☐ Cardiac Echo
- ☐ Carotid Doppler
- ☐ Groin
- ☐ OB Less Than 14 Weeks
- ☐ Prostate
- ☐ Pelvice w/ Transvaginal (if needed)
- ☐ US Renal
- ☐ US Renal w/ Doppler
- ☐ US Breast ☐ UNILATERAL ☐ BILATERAL
- ☐ Soft Tissue _____
- ☐ Testicular/Scrotal ☐ w/Doppler
- ☐ Thyroid
- ☐ Transvaginal only

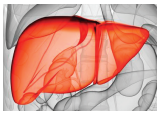
VENOUS/ARTEROA DOPPLER (Circle One or Both)

- ☐ Lower Extremity ☐ R ☐ L ☐ BILAT
- ☐ Upper Extremity ☐ R ☐ L ☐ BILAT
- ☐ Other _____

X-RAY

- ☐ Skull Complete
- ☐ Facial Bones
- ☐ Sinuses
- ☐ Chest PA & Lateral
- ☐ Ribs (specify) ☐ Bilateral ☐ R ☐ L
- ☐ Cervical Spine 2v, 4v, 6 view
- ☐ Thoracic Spine
- ☐ Lumbar Spine 2v, 4v, 6 View
- ☐ KUB
- ☐ Abdomen Series
- ☐ Pelvis AP
- ☐ Hip ☐ R ☐ L
- ☐ Femur ☐ R ☐ L
- ☐ Knee ☐ R ☐ L
- ☐ Tibia/Fibula ☐ R ☐ L
- ☐ Ankle ☐ R ☐ L
- ☐ Foot ☐ R ☐ L
- ☐ Toe (specify) _____
- ☐ Shoulder ☐ R ☐ L
- ☐ Humerus ☐ R ☐ L
- ☐ Elbow ☐ R ☐ L
- ☐ Forearm ☐ R ☐ L
- ☐ Wrist ☐ R ☐ L
- ☐ Hand ☐ R ☐ L
- ☐ Finger (specify) _____
- ☐ Other _____

FIBROSCAN LIVER



- ☐ Routine Exam
- ☐ Hepatitis ☐ A ☐ B ☐ C
- ☐ Non-Alcoholic Fatty Liver Disease (NAFLD)
- ☐ Non-Alcoholic Steatohepatitis (NASH)
- ☐ Alcoholic Liver Disease (ALD)
- ☐ Other _____

DEXA

☐ **LUNAR iDEXA2** ___ **Adult Dexa** ___ **Pediatric Dexa** ___ **Body Composition** ___ **Research Subject**

Bone and Metabolic Health