spectrummrionline.com

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Chino, CA 91710

(909) 591-5587
Fax: (909) 591-0538

Appointment Date: _____ Time: _____

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

Phone: (Home) _____(Work) _____(Cell) _____

Referring Physician: _____ Signature: _____

Clinical Diagnosis: _____

1. MRI

❑ **Contrast** ❑ **Yes** ❑ **No**

❑ **3D RECON**
❑ Abdomen
❑ Angiography-carotids, circle of willis
❑ Brain
❑ Breast (Implants or Cancer)
❑ Cervical Spine
❑ Chest
❑ IAC
❑ Lumbar-Sacral Spine
❑ MRA-contrast enhance
❑ MRCP
❑ MR Venogram
❑ Nasopharynx
❑ Pelvis
❑ Shoulder
❑ Soft Tissue Neck
❑ Thoracic Spine
❑ TMJ Scan
❑ Peripheral Angiography
❑ Prostate
❑ Pituitary
❑ Upper or Lower Extremity_____
❑ Others_____

2. Arthrograms

❑ Right ❑ Left
❑ Knee ❑ Shoulder
❑ Elbow ❑ Wrist ❑ Hip

3. ULTRASOUND

❑ Abdomen-General
❑ Breast Lt, Rt, or Both>(Circle one)
❑ Carotid Duplex
❑ Echocardiogram
❑ Gallbladder
❑ Kidney
❑ OB
❑ Pelvic
❑ Prostate
❑ Testicles
❑ Thyroid
❑ Trans-rectal
❑ Vascular Arterial
❑ Vascular Venous
❑ Others_____

4. DENTAL

❑ Maxilla
❑ Mandible

Comments: _____

_____

_____

SPECTRUM MRI & FULL BODY IMAGING CENTER
(Please fax insurance information to: (909) 591-0538)