

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

Primary Insurance: _____ Secondary Insurance: _____

Pre-Auth. #: _____ Dates Pre-Auth. is valid: _____

CAT Scans of the Abdomen and Pelvis May Require an Oral Prep Before the Exam.

Diagnosis (REQUIRED): _____

Physician's Signature (REQUIRED): _____ DX Code (REQUIRED): _____

ARRIVAL TIME: _____ APPOINTMENT TIME: _____ APPOINTMENT DATE: _____

MRI/MRA IMAGING	ULTRASOUND IMAGING	CT IMAGING	X-RAY
<input type="checkbox"/> The following test(s) with Gadolinium as needed HEAD & NECK <input type="checkbox"/> MRI Brain <input type="checkbox"/> Orbits <input type="checkbox"/> IAC's <input type="checkbox"/> MRA Brain <input type="checkbox"/> TMJ's <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> MRA Carotids <input type="checkbox"/> Sella/Pituitary BODY <input type="checkbox"/> Liver <input type="checkbox"/> Adrenals <input type="checkbox"/> MRCP (NPO) <input type="checkbox"/> Kidney(s) <input type="checkbox"/> Chest <input type="checkbox"/> MRA Renal Artery <input type="checkbox"/> MRI Abdomen: Specify attention to: _____ <input type="checkbox"/> MRI Pelvis: Specify attention to: _____ SPINE <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar Special attention to: _____ Has the patient ever had back surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, When? _____ EXTREMITY JOINTS <input type="checkbox"/> Shoulder <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Elbow <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Wrist <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Hip <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Knee <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Ankle <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Foot <input type="checkbox"/> L <input type="checkbox"/> R EXTREMITY NON-JOINTS Specify body part: _____ <input type="checkbox"/> Left <input type="checkbox"/> Right	*See Preps on Back* <input type="checkbox"/> ABDOMEN (includes GB, Liver, Kidney(s), Aorta, & Bladder) <input type="checkbox"/> RETROPERITONEAL COMPLETE (includes Kidneys, Pancreas, Aorta, & Spleen) <input type="checkbox"/> RETROPERITONEAL LIMITED (single organ) <input type="checkbox"/> Kidney <input type="checkbox"/> Aorta <input type="checkbox"/> Bladder <input type="checkbox"/> RAS – Renal Artery Stenosis <input type="checkbox"/> PELVIC w/Transvaginal (as needed) OB-GYN Estimated fetal age: _____ <input type="checkbox"/> OB Under 14 weeks <input type="checkbox"/> OB Over 14 weeks <input type="checkbox"/> OB Single gestation <input type="checkbox"/> OB Multiple gestations <input type="checkbox"/> Biophysical profile without Non-stress testing VASCULAR <input type="checkbox"/> Venous Doppler Extremity Upper <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Venous Doppler Extremity Lower <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Upper Extremity Non-Vascular <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Lower Extremity Non-Vascular <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Carotid Arteries <input type="checkbox"/> Groin MISCELLANEOUS <input type="checkbox"/> Breast <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral **If you have had a previous mammogram, bring the films with you to appointment** OTHER <input type="checkbox"/> Thyroid <input type="checkbox"/> Soft-Tissue Neck <input type="checkbox"/> Testicular Special instructions: _____ _____ _____	<input type="checkbox"/> The following test(s) I.V. and/or Oral Contrast as needed HEAD & NECK <input type="checkbox"/> Head <input type="checkbox"/> Maxillofacial/Sinus <input type="checkbox"/> Neck (soft tissue) <input type="checkbox"/> Orbits <input type="checkbox"/> Temporal Bones <input type="checkbox"/> Other BODY <input type="checkbox"/> Abdomen and Pelvis (both) <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Chest <input type="checkbox"/> CT Urogram <input type="checkbox"/> CT Renal Stone EXTREMITY <input type="checkbox"/> Right <input type="checkbox"/> Left Specify body part: _____ SPINE <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar CT ANGIOGRAPHY Specify body part: _____ <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Renal <input type="checkbox"/> Head <input type="checkbox"/> Carotid <input type="checkbox"/> Aorta Thoracic Abdom. <input type="checkbox"/> Aorta & Runoff <input type="checkbox"/> Upper Extremity <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Lower Extremity <input type="checkbox"/> L <input type="checkbox"/> R SPECIALTIES <input type="checkbox"/> Calcium Score <input type="checkbox"/> 3D Rendering <input type="checkbox"/> Virtual Colonoscopy <input type="checkbox"/> Coronary Artery (Coronaries REQUIRE very specialized preparation) CREATININE results are required if the patient is over 60 years old, an insulin dependent diabetic or has a history of renal insufficiency. The Creatinine level must have been drawn within the last 3 months. Date drawn: _____ Creatinine level: _____	<input type="checkbox"/> Skull <input type="checkbox"/> Orbits <input type="checkbox"/> Facial Bones <input type="checkbox"/> Sinuses <input type="checkbox"/> Chest Pa/Lateral <input type="checkbox"/> Sternum <input type="checkbox"/> Rib <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Both <input type="checkbox"/> Clavicle <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Both <input type="checkbox"/> Shoulder <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Both <input type="checkbox"/> Humerus <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Both <input type="checkbox"/> Elbow <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Both <input type="checkbox"/> Forearm <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Both <input type="checkbox"/> Wrist <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Both <input type="checkbox"/> Hand <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Both <input type="checkbox"/> Finger Digit <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Both <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Pelvis <input type="checkbox"/> Hip <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Both <input type="checkbox"/> Femur <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Both <input type="checkbox"/> Knee <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Both <input type="checkbox"/> Tibia/Fibia <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Both <input type="checkbox"/> Ankle <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Both <input type="checkbox"/> Foot <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Both <input type="checkbox"/> Scoliosis Screen <input type="checkbox"/> Scoliosis Series <input type="checkbox"/> Abdomen (Kub) <input type="checkbox"/> Soft Tissue <input type="checkbox"/> Bone Age Study <input type="checkbox"/> Other _____



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MRI: If you have a **Pacemaker, Defibrillator or Cochlear Implants** (ear) you **CANNOT** have an MRI. Also, if you have brain aneurysm clips or have had metal removed from your eyes you may have to have X-rays **AT LEAST** one **DAY PRIOR** to your MRI.

CT Preps: Nothing by mouth 4 hours before exam time – if you are over 70 years old or an Insulin dependent diabetic prior blood work will be required. If you need to take any medications, take them with as little water as possible.

CT Abdomen/Pelvis: Some CTs require that you pick-up a bottle of Barium prep at least the day before your exam.

4 hours before the exam, do not eat or drink anything.

2 hours before the exam, drink 1/2 the bottle of Barium.

1 hour before the exam, drink remainder of the Barium.

Pelvic & OB Ultrasound Prep: Void your bladder then **drink 32 oz.** of water beginning 1-1/4 to 1-1/2 hours before your exam time and complete drinking 1 hour prior to your exam time. ****DO NOT EMPTY YOUR BLADDER**** If your bladder is NOT full your test may have to be rescheduled.

Abdominal Ultrasound Prep: DO NOT eat or drink anything at least 8 hours prior to your exam time. If medication is needed, take with a small amount of water.

If Ultrasound abdominal and pelvis are ordered together, follow the abdominal prep AND drink 32 oz. of water as directed in the Pelvic Ultrasound Prep.

Renal Ultrasound Prep (Kidney): Drink 16 oz. of water 1-1/4 to 1-1/2 hours before your exam time and complete drinking 1 hour prior to your exam time. ****DO NOT EMPTY YOUR BLADDER****

Directions:

Traveling from the South:

Take I-81 North to VA-37 North/Exit 310. Turn Left onto VA-37 N. Take US-522 Exit toward Winchester. Turn right onto N. Frederick Pike. Just past the second light, turn Left on to Exeter Drive. Drive around the back of the Trex Building for the Winchester Imaging entrance and parking.

Traveling from the North:

Take I-81 South to US-11 exit 317 toward VA-37. Keep right at the fork to go to Martinsburg Pike. Take US-522 Exit toward Winchester. Just past the second light, turn Left on to Exeter Drive. Drive around the back of the Trex Building for the Winchester Imaging entrance and parking.

