



NAME: _____ DOB: _____ PHONE: (_____) _____

REFERRING PHYSICIAN PRINT HERE: _____

REFERRING PHYSICIAN SIGNATURE: _____ DATE: _____

DIAGNOSIS: _____

WET READING

YES

NO

CONTRAST AT RADIOLOGIST DISCRETION

| MRI | CT | DIGITAL MAMMOGRAPHY | X-RAY | OAKS LOCATION |
|---|--|--|--|---|
| <input type="checkbox"/> with contrast <input type="checkbox"/> without contrast SPECIAL ATTENTION: _____ <input type="checkbox"/> ABDOMEN <input type="checkbox"/> ANKLE R / L <input type="checkbox"/> BRAIN <input checked="" type="checkbox"/> BREAST-BILATERAL OAKS DIAGNOSTIC W & W/O CONTRAST <input type="checkbox"/> BREAST-IMPLANT (RUPTURE) W/O CONTRAST <input type="checkbox"/> C.SPINE <input type="checkbox"/> CHEST <input type="checkbox"/> FOOT R / L <input type="checkbox"/> HAND R / L <input type="checkbox"/> IAC'S <input type="checkbox"/> KNEE R / L <input type="checkbox"/> L.SPINE <input type="checkbox"/> LOWER EXTREMITY R / L <input type="checkbox"/> MRCP <input type="checkbox"/> NECK SOFT TISSUE <input type="checkbox"/> ORBITS <input type="checkbox"/> PELVIS <input type="checkbox"/> PITUITARY <input type="checkbox"/> PROSTATE <input type="checkbox"/> RENAL/KIDNEY <input type="checkbox"/> SHOULDER R / L <input type="checkbox"/> T.SPINE <input type="checkbox"/> TMJ <input type="checkbox"/> TEMPORAL BONE <input type="checkbox"/> UPPER EXTREMITY R / L <input type="checkbox"/> WRIST R / L <input type="checkbox"/> OTHER _____ | <input type="checkbox"/> with contrast <input type="checkbox"/> without contrast SPECIAL ATTENTION: _____ <input type="checkbox"/> 3D VIEWS W/EXAM <input type="checkbox"/> ABDOMEN <input type="checkbox"/> ABDOMEN & PELVIS <input type="checkbox"/> BRAIN <input type="checkbox"/> CERVICAL SPINE W/REFORM <input type="checkbox"/> CHEST <input type="checkbox"/> CHEST PE PROTOCOL <input type="checkbox"/> CHEST HIRes (NO CONTRAST) <input type="checkbox"/> CORONARY CALCIUM SCORING <input type="checkbox"/> DENTAL <input type="checkbox"/> MANDIBLE <input type="checkbox"/> MAXILLARY <input type="checkbox"/> FACIAL BONES <input type="checkbox"/> KUB <input type="checkbox"/> LOWER EXTREMITY R / L SPECIFY: _____ <input type="checkbox"/> LUMBAR SPINE W/REFORM <input type="checkbox"/> LUMBAR SPINE (POST DISCOGRAM) _____ LEVELS <input type="checkbox"/> MASTOIDS <input type="checkbox"/> ORBITS <input type="checkbox"/> NECK SOFT TISSUE <input type="checkbox"/> PELVIS <input type="checkbox"/> SCANOGRAM <input type="checkbox"/> SINUSES COMPLETE <input type="checkbox"/> SINUSES LIMITED <input type="checkbox"/> THORACIC SPINE W/REFORM <input type="checkbox"/> TEMPORAL BONE / IAC <input type="checkbox"/> UPPER EXTREMITY R / L SPECIFY _____ <input type="checkbox"/> UROGRAM <input type="checkbox"/> OTHER _____ | BONE DENSITY <input type="checkbox"/> DEXASCAN ULTRASOUND <input type="checkbox"/> ABDOMEN COMPLETE <input type="checkbox"/> ABDOMEN LIMITED <input type="checkbox"/> ABDOMINAL AORTA W/DUPLEX <input type="checkbox"/> BLADDER <input type="checkbox"/> BREAST R / L <input checked="" type="checkbox"/> ECHOCARDIOGRAM <input type="checkbox"/> EXTREMITY NON VASCULAR <input type="checkbox"/> LOWER <input type="checkbox"/> UPPER <input type="checkbox"/> INFANT <input type="checkbox"/> CRANIAL <input type="checkbox"/> HIP <input type="checkbox"/> SPINAL CANAL <input type="checkbox"/> KIDNEY/RENAL <input type="checkbox"/> NECK SOFT TISSUE <input type="checkbox"/> OBSTETRICAL <input type="checkbox"/> UNDER 12 WEEKS <input type="checkbox"/> OVER 13 WEEKS <input type="checkbox"/> BPP <input type="checkbox"/> PELVIC <input type="checkbox"/> PROSTATE <input type="checkbox"/> RENAL ARTERY W/DUPLEX <input type="checkbox"/> SCROTUM <input type="checkbox"/> THYROID <input type="checkbox"/> ULTRA HYSTEROSONOGRAPHY <input type="checkbox"/> OTHER _____ | <input type="checkbox"/> ABDOMEN-SINGLE VIEW <input type="checkbox"/> ABDOMEN - COMPLETE <input type="checkbox"/> ANKLE R / L <input type="checkbox"/> BONE AGE <input type="checkbox"/> BONE LENGTH <input type="checkbox"/> BONE SURVEY <input type="checkbox"/> CERVICAL SPINE AP/LAT <input type="checkbox"/> CERVICAL SPINE 5 VIEWS <input type="checkbox"/> CERVICAL SPINE FLEX & EXT <input type="checkbox"/> CHEST SINGLE VIEW <input type="checkbox"/> CHEST (TWO VIEW) <input type="checkbox"/> CLAVICAL R / L <input type="checkbox"/> ELBOW R / L <input type="checkbox"/> FACIAL BONES <input type="checkbox"/> FEMUR R / L <input type="checkbox"/> FOOT R / L <input type="checkbox"/> OS CALCIS (HEEL) R / L <input type="checkbox"/> TOE R / L <input type="checkbox"/> FOREARM R / L <input type="checkbox"/> HAND R / L <input type="checkbox"/> FINGER R / L <input type="checkbox"/> HIP R / L <input type="checkbox"/> HUMERUS R / L <input type="checkbox"/> KNEE AP AND LAT R / L <input type="checkbox"/> KNEE (4VIEWS) R / L <input type="checkbox"/> KUB <input type="checkbox"/> LOWER LEG (TIB & FIB) R / L <input type="checkbox"/> LUMBAR SPINE AP/LAT <input type="checkbox"/> LUMBAR SPINE W/OBLIQUES <input type="checkbox"/> LUMBAR SPINE FLEX & EXT <input type="checkbox"/> NASAL BONE <input type="checkbox"/> NECK SOFT TISSUE <input type="checkbox"/> ORBITS <input type="checkbox"/> PELVIS <input type="checkbox"/> RIB R / L <input type="checkbox"/> SACRUM & COCCYX <input type="checkbox"/> SCOLIOSIS <input type="checkbox"/> SHOULDER R / L <input type="checkbox"/> SI JOINTS <input type="checkbox"/> SINUSES (1 VIEW) <input type="checkbox"/> SINUSES (COMPLETE) <input type="checkbox"/> SKULL <input type="checkbox"/> TMJ <input type="checkbox"/> THORACIC SPINE <input type="checkbox"/> WRIST R / L <input type="checkbox"/> OTHER _____ | CARDIAC <input type="checkbox"/> ECHOCARDIOGRAM <input type="checkbox"/> STRESS ECHO <input type="checkbox"/> EST/EXERCISE STRESS TEST FLUOROSCOPY <input type="checkbox"/> BARIUM ENEMA <input type="checkbox"/> ESOPHAGRAM <input type="checkbox"/> SMALL BOWEL <input type="checkbox"/> UPPER GI <input type="checkbox"/> OTHER _____ GENITOURINARY <input type="checkbox"/> HSG/HYSTEROSALPINGOGRAM <input type="checkbox"/> URETHROGRAM <input type="checkbox"/> VCUG <input type="checkbox"/> IVP W/CT CUTS SUNTREE/OAKS <input type="checkbox"/> OTHER _____ NUCLEAR MEDICINE <input type="checkbox"/> BILIARY/HIDA <input type="checkbox"/> BILIARY/HIDA W/CCK <input type="checkbox"/> BONE (WHOLE BODY) <input type="checkbox"/> BONE (3 PHASE) SPECIFY _____ <input type="checkbox"/> CERETEC (WBC) <input type="checkbox"/> GASTRIC EMPTYING <input type="checkbox"/> MUGA SCAN <input type="checkbox"/> STRESS W/CARDIOLITE <input type="checkbox"/> CHEMICAL STRESS W/LEXISCAN <input type="checkbox"/> RENAL MAG 3 <input type="checkbox"/> RENAL LASIX/MAG 3 <input type="checkbox"/> THYROID UPTAKE & SCAN <input type="checkbox"/> SENTINEL NODE (BREAST) <input type="checkbox"/> SENTINEL NODE (NON-BREAST) <input type="checkbox"/> OTHER _____ |
| MR ANGIOGRAPHY <input type="checkbox"/> VESSEL(S) <input type="checkbox"/> AORTA (ABDOMEN) <input type="checkbox"/> AORTA (THORACIC) <input type="checkbox"/> BRAIN <input type="checkbox"/> CAROTID <input checked="" type="checkbox"/> LOWER EXTREMITY OAKS RUN OFF <input type="checkbox"/> PELVIC <input type="checkbox"/> PULMONARY <input type="checkbox"/> RENAL <input type="checkbox"/> OTHER _____ | CT ANGIOGRAPHY <input type="checkbox"/> ABDOMINAL AORTA <input type="checkbox"/> BRAIN/CEREBRAL <input type="checkbox"/> CHEST/HEART/CORONARY <input type="checkbox"/> LOWER EXTREMITY (TO INCLUDE PELVIS) <input type="checkbox"/> NECK CAROTIDS <input type="checkbox"/> PELVIC <input type="checkbox"/> RENALS <input type="checkbox"/> THORACIC AORTA <input type="checkbox"/> UPPER EXTREMITY | ULTRASOUND VASCULAR <input type="checkbox"/> CAROTID DOPPLER <input type="checkbox"/> ARTERIAL DOPPLER W/ABI <input type="checkbox"/> LOWER EXTREMITY R / L <input type="checkbox"/> UPPER EXTREMITY R / L <input type="checkbox"/> DEEP VEIN <input type="checkbox"/> LOWER R / L <input type="checkbox"/> UPPER R / L <input type="checkbox"/> VENOUS INSUFFICIENCY R / L | SPECIAL PROCEDURES <input type="checkbox"/> MYELOGRAM W/CT <input type="checkbox"/> CERVICAL <input type="checkbox"/> LUMBAR <input type="checkbox"/> THORACIC <input type="checkbox"/> ARTHROGRAM <input type="checkbox"/> with CT <input type="checkbox"/> with MRI <input type="checkbox"/> ANKLE R / L <input type="checkbox"/> ELBOW R / L <input type="checkbox"/> HIP R / L <input type="checkbox"/> KNEE R / L <input type="checkbox"/> SHOULDER R / L <input type="checkbox"/> WRIST R / L | |

EXAM PREP *



Ph (321)726-3800
Fax (321) 726-3842

CREATININES PERFORMED ON-SITE

CREATININES REQUIRED

- WITHIN 90 DAYS FOR MRI
- WITHIN 30 DAYS FOR CT

MRI:

ALL MRA STUDIES WITH CONTRAST

- OVER AGE 60
- DIABETIC
- KIDNEY DISEASE HISTORY
(EX. HISTORY KIDNEY FAILURE,
ONE KIDNEY)

CT:

ALL CT STUDIES W/ CONTRAST

- OVER AGE 70
- KIDNEY DISEASE HISTORY

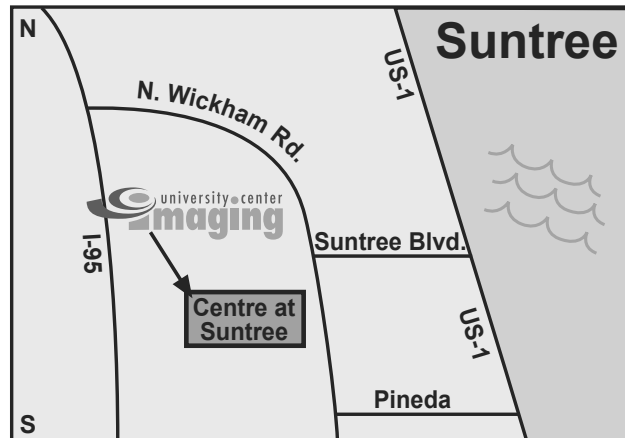
NOTHING TO EAT 4 HOURS PRIOR TO PROCEDURE:

- ALL CAT SCANS REQUIRING
CONTRAST MEDIA
- ARTHROGRAMS
- MYELOGRAMS
- MRCP

EXAMS REQUIRING RETURN IMAGING OR IN 2 PARTS:

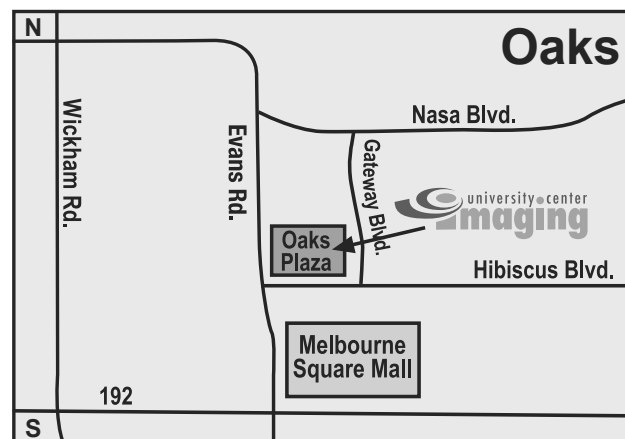
- NUCLEAR MEDICINE BONE
SCANS (3 PHASE & WHOLE BODY)
- NUCLEAR MEDICINE THYROID
SCANS
- NUCLEAR MEDICINE CERETEC
(WBC)

* Call facility or visit us online for
more detailed prep instructions
or to confirm facility location for
appointment.



CENTRE AT SUNTREE

6300 North Wickham Rd., Suite 100
Melbourne, FL 32940
Monday - Friday
8:00am - 5:00pm



OAKS PLAZA

1800 West Hibiscus Blvd., Suite 100
Melbourne, FL 32901
Monday - Friday
7:00am - 6:00pm