university center imaging
an MTT Corporation facility

Tel (321) 726-3800 • Fax (321) 726-3842

ACR AMERICAN COLLEGE OF RADIOLOGY ACCREDITED FACILITY

OAKS PLAZA
1800 W. Hibiscus Blvd., Ste. 100
Melbourne, Florida 32901

SUNTREE
6300 N. Wickham Rd., Ste 100
Melbourne, Florida 32940

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

REFERRING PHYSICIAN PRINT HERE: _____ SIGNATURE: _____

APPOINTMENT INFORMATION DATE: _____ TIME: _____

DIAGNOSIS: _____ **WET READING** YES NO

❑ CONTRAST AT RADIOLOGIST DISCRETION

MRI

❑ With Contrast
❑ Without Contrast
SPECIAL ATTENTION:
_____
❑ ABDOMEN
❑ ANKLE R / L
❑ BRAIN
❑ BREAST– BILATERAL W & W/O CONTRAST *OAKS*
❑ BREAST– UNILATERAL W & W/O CONTRAST
❑ BREAST– IMPLANT (RUPTURE) W/O CONTRAST
❑ PROSTATE
❑ C.SPINE
❑ CHEST
❑ FOOT R / L
❑ HAND R / L
❑ IAC'S
❑ KNEE R / L
❑ L.SPINE
❑ LOWER EXTREMITY R / L
❑ MRCP
❑ NECK SOFT TISSUE
❑ ORBITS
❑ PELVIS
❑ PITUITARY
❑ RENAL/KIDNEY
❑ SHOULDER R / L
❑ T.SPINE
❑ TMJ
❑ TEMPORAL BONE
❑ UPPER EXTREMITY R / L
❑ WRIST R / L
❑ OTHER _____

MR ANGIOGRAPHY

❑ VESSEL(S)
❑ AORTA (ABDOMEN)
❑ AORTA (THORACIC)
❑ BRAIN
❑ CAROTID
❑ LOWER EXTREMITY RUN OFF *OAKS*
❑ PELVIC
❑ PULMONARY
❑ RENAL
❑ OTHER _____

CT

❑ With Contrast
❑ Without Contrast
SPECIAL ATTENTION:
_____
❑ 3D VIEWS W/EXAM
_____
❑ ABDOMEN
❑ ABDOMEN & PELVIS
❑ BRAIN
❑ CERVICAL SPINE W/REFORM
❑ CHEST
❑ LOW DOSE LUNG SCREEN
❑ CHEST PE PROTOCOL
❑ CHEST HIRes
❑ DENTAL ❑ MANDIBLE ❑ MAXILLARY
❑ FACIAL BONES
❑ KUB
❑ LOWER EXTREMITY R / L
SPECIFY:_____
❑ LUMBAR SPINE W/REFORM
❑ LUMBAR SPINE (POST DISCOGRAM)
_____ LEVELS
❑ MASTOIDS
❑ ORBITS
❑ NECK SOFT TISSUE
❑ PELVIS
❑ SCANOGRAM
❑ SINUSES COMPLETE
❑ SINUSES LIMITED
❑ THORACIC SPINE W/REFORM
❑ TEMPORAL BONE / IAC
❑ UPPER EXTREMITY R / L
SPECIFY_____
❑ UROGRAM
❑ OTHER_____

CT ANGIOGRAPHY

❑ ABDOMINAL AORTA
❑ BRAIN/CEREBRAL
❑ CARDIAC CORONARY/CCTA
❑ LOWER EXTREMITY (TO INCLUDE PELVIS)
❑ NECK CAROTIDS
❑ PELVIC
❑ RENALS
❑ THORACIC AORTA
❑ UPPER EXTREMITY

ULTRASOUND

❑ ABDOMEN COMPLETE
❑ ABDOMEN LIMITED/RUQ
❑ ABDOMINAL AORTA W/DUPLEX
❑ BLADDER
❑ BREAST R / L
❑ ECHOCARDIOGRAM
❑ EXTREMITY NON VASCULAR
❑ LOWER
❑ UPPER
❑ HERNIA
❑ INGUINAL
❑ UMBILICAL
❑ INFANT
❑ CRANIAL
❑ HIP
❑ SPINAL CANAL
❑ KIDNEY/RENAL
❑ NECK SOFT TISSUE
❑ OBSTETRICAL
❑ UNDER 12 WEEKS
❑ OVER 13 WEEKS
❑ BPP
❑ PELVIC
❑ PROSTATE
❑ SCROTUM
❑ THYROID
❑ ULTRA HYSTEROSONOGRAPHY
❑ OTHER _____

ULTRASOUND VASCULAR

❑ CAROTID DOPPLER
❑ ARTERIAL DOPPLER W/ABI
❑ LOWER EXTREMITY R / L
❑ UPPER EXTREMITY R / L
❑ DEEP VEIN
❑ LOWER R / L
❑ UPPER R / L
❑ RENAL ARTERY W/DUPLEX
❑ VENOUS INSUFFICIENCY R / L

DIGITAL MAMMOGRAPHY

❑ BILATERAL SCREENING
❑ BILATERAL DIAGNOSTIC W/ULTRASOUND (IF MEDICALLY NECESSARY)
❑ UNILATERAL DIAGNOSTIC W/ULTRASOUND (IF MEDICALLY NECESSARY)
IMPLANTS ___YES___NO

BONE DENSITY

❑ DEXASCAN

X-RAY

❑ ABDOMEN - SINGLE VIEW
❑ ABDOMEN - COMPLETE
❑ ANKLE R / L
❑ BONE AGE
❑ BONE SURVEY
❑ CERVICAL SPINE AP/LAT
❑ CERVICAL SPINE 5 VIEWS
❑ CERVICAL SPINE FLEX & EXT
❑ CHEST SINGLE VIEW
❑ CHEST (TWO VIEW)
❑ CLAVICLE R / L
❑ ELBOW R / L
❑ FACIAL BONES
❑ FEMUR R / L
❑ FOOT R / L
❑ OS CALCIS (HEEL) R / L
❑ TOE R / L_____
❑ FOREARM R / L
❑ HAND R / L
❑ FINGER R / L_____
❑ HIP R / L
❑ HUMERUS R / L
❑ KNEE (3VIEWS) R / L
❑ KUB
❑ LOWER LEG (TIB & FIB) R / L
❑ LUMBAR SPINE AP/LAT
❑ LUMBAR SPINE W/OBLIQUES
❑ LUMBAR SPINE FLEX & EXT
❑ NASAL BONE
❑ NECK SOFT TISSUE
❑ ORBITS
❑ PELVIS
❑ RIB R / L
❑ SACRUM & COCCYX
❑ SCOLIOSIS *OAKS*
❑ SHOULDER R / L
❑ SI JOINTS
❑ SINUSES (1 VIEW)
❑ SINUSES (COMPLETE)
❑ SKULL
❑ TMJ
❑ THORACIC SPINE
❑ WRIST R / L
❑OTHER _____

OAKS LOCATION

CARDIAC

❑ CORONARY CALCIUM SCORING
❑ ECHOCARDIOGRAM *(SUNTREE/OAKS)*
❑ STRESS ECHO
❑ EST/EXERCISE STRESS TEST

FLUOROSCOPY

❑ BARIUM ENEMA
❑ ESOPHAGRAM
❑ SMALL BOWEL
❑ UPPER GI
❑ OTHER_____

GENITOURINARY

❑ HSG/HYSTEROSALPINGOGRAM
❑ URETHROGRAM
❑ VCUG
❑ IVP W/CT CUTS *(SUNTREE/OAKS)*
❑ OTHER_____

NUCLEAR MEDICINE

❑ BILIARY/HIDA W/CCK
❑ BILIARY/HIDA
❑ BONE (WHOLE BODY)
❑ BONE (3 PHASE)
SPECIFY _____
❑ CERETEC (WBC)
❑ GASTRIC EMPTYING
❑ MUGA SCAN
❑ STRESS W/CARDIOLITE
❑ CHEMICAL STRESS W/LEXISCAN
❑ RENAL MAG 3
❑ RENAL LASIX/MAG 3
❑ THYROID UPTAKE & SCAN
❑ SENTINEL NODE (BREAST)
❑ SENTINEL NODE (NON-BREAST)
❑ OTHER_____

SPECIAL PROCEDURES

❑ **MYELOGRAM W/CT**
❑ CERVICAL
❑ LUMBAR
❑ THORACIC
❑ **ARTHROGRAM**
❑ with CT
❑ with MRI
❑ ANKLE R / L
❑ ELBOW R / L
❑ HIP R / L
❑ KNEE R / L
❑ SHOULDER R / L
❑ WRIST R / L

r.05-17

EXAM PREP *

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Ph: (321) 726-3800
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CREATININES PERFORMED ON-SITE

CREATININES REQUIRED

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

MRI:

ALL 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
- DIABETIC

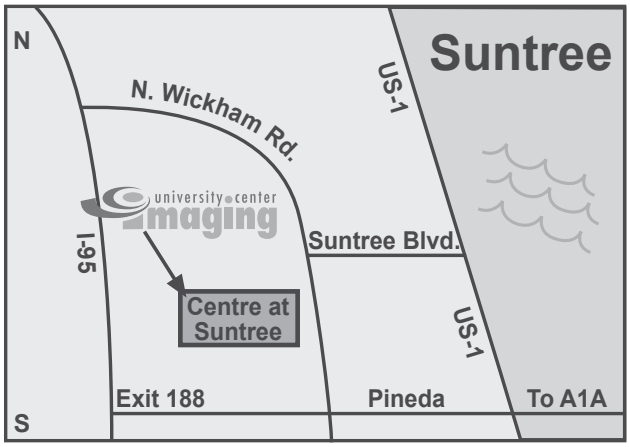
NOTHING TO EAT 4 HOURS PRIOR TO PROCEDURE:

- ALL CAT SCANS REQUIRING CONTRAST MEDIA
- ARTHROGRAMS
- MYELOGRAMS
- MRCP
- MRI ABDOMEN AND/OR PELVIS

EXAMS REQUIRING RETURN IMAGING OR IN 2 PARTS:

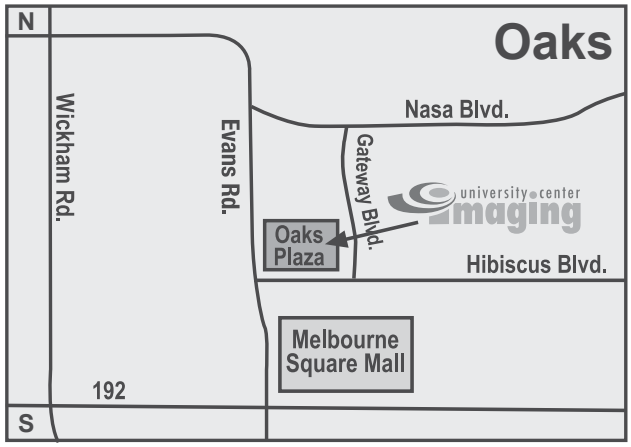
- NUCLEAR MEDICINE BONE SCANS (3 PHASE & WHOLE BODY)
- NUCLEAR MEDICINE THYROID SCANS
- NUCLEAR MEDICINE CERETEC (WBC)

**** 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
X-Ray Hours: 8am - 6pm

ACR American College of Radiology Accredited Facility
IAC Intersocietal Accreditation Commission Accredited Facility Echocardiography
Designated Lung Cancer Screening Center American College of Radiology