



NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ PHONE: (\_\_\_\_\_) \_\_\_\_\_ DATE: \_\_\_\_\_

CELL PHONE: (\_\_\_\_\_) \_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_

REFERRING PHYSICIAN PRINT HERE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

APPOINTMENT INFORMATION DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_ **WET READING**  YES  NO

**CONTRAST AT RADIOLOGIST DISCRETION**

MRI	CT	ULTRASOUND	BONE DENSITY	OAKS LOCATION
<input type="checkbox"/> With Contrast <input type="checkbox"/> Without Contrast <b>SPECIAL ATTENTION:</b> <input type="checkbox"/> ABDOMEN <input type="checkbox"/> ANKLE R / L <input type="checkbox"/> BRAIN <input type="checkbox"/> BREAST- BILATERAL W & W/O CONTRAST <b>OAKS</b> <input type="checkbox"/> BREAST- UNILATERAL W & W/O CONTRAST <input type="checkbox"/> BREAST- IMPLANT (RUPTURE) W/O CONTRAST <input type="checkbox"/> PROSTATE <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"/> 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 _____ <b>MR ANGIOGRAPHY</b> <input type="checkbox"/> VESSEL(S) <input type="checkbox"/> AORTA (ABDOMEN) <input type="checkbox"/> AORTA (THORACIC) <input type="checkbox"/> BRAIN <input type="checkbox"/> CAROTID <input type="checkbox"/> LOWER EXTREMITY RUN OFF <b>OAKS</b> <input type="checkbox"/> PELVIC <input type="checkbox"/> PULMONARY <input type="checkbox"/> RENAL <input type="checkbox"/> OTHER _____	<input type="checkbox"/> W/ IV Contrast <input type="checkbox"/> Oral <input type="checkbox"/> W/O IV Contrast <input type="checkbox"/> Oral <b>SPECIAL ATTENTION:</b> <input type="checkbox"/> W/ METAL REDUCTION <b>SUNTREE</b> <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"/> LOW DOSE LUNG SCREEN <input type="checkbox"/> CHEST PE PROTOCOL <input type="checkbox"/> CHEST HIRes <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 <b>SPECIFY:</b> _____ <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 <b>SPECIFY</b> _____ <input type="checkbox"/> UROGRAM <input type="checkbox"/> OTHER _____ <b>CT ANGIOGRAPHY</b> <input type="checkbox"/> ABDOMINAL AORTA <input type="checkbox"/> BRAIN/CEREBRAL <input type="checkbox"/> CARDIAC CORONARY/CCTA <b>OAKS</b> <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	<input type="checkbox"/> ABDOMEN COMPLETE <input type="checkbox"/> ABDOMEN LIMITED/RUQ <input type="checkbox"/> ABDOMINAL AORTA W/DUPLEX <input type="checkbox"/> BLADDER <input type="checkbox"/> BREAST R / L <input type="checkbox"/> ECHOCARDIOGRAM <input type="checkbox"/> EXTREMITY NON VASCULAR <input type="checkbox"/> LOWER <input type="checkbox"/> UPPER <input type="checkbox"/> HERNIA <input type="checkbox"/> INGUINAL <input type="checkbox"/> UMBILICAL <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"/> SCROTUM <input type="checkbox"/> THYROID <input type="checkbox"/> ULTRAHYSTEROSONOGRAPHY <input type="checkbox"/> OTHER _____ <b>ULTRASOUND VASCULAR</b> <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"/> RENAL ARTERY W/DUPLEX <input type="checkbox"/> VENOUS INSUFFICIENCY R / L <b>DIGITAL MAMMOGRAPHY</b> <input type="checkbox"/> BILATERAL SCREENING <input type="checkbox"/> BILATERAL DIAGNOSTIC W/ULTRASOUND (IF MEDICALLY NECESSARY) <input type="checkbox"/> UNILATERAL DIAGNOSTIC W/ULTRASOUND (IF MEDICALLY NECESSARY) IMPLANTS ___YES___NO	<input type="checkbox"/> DEXASCAN <b>X-RAY</b> <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 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"/> CLAVICLE 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 (3VIEWS) 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 <b>OAKS</b> <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 _____	<b>CARDIAC</b> <input type="checkbox"/> CORONARY CALCIUM SCORING <input type="checkbox"/> ECHOCARDIOGRAM (SUNTREE/OAKS) <input type="checkbox"/> STRESS ECHO <input type="checkbox"/> EST/EXERCISE STRESS TEST <b>FLUOROSCOPY</b> <input type="checkbox"/> BARIUM ENEMA <input type="checkbox"/> ESOPHAGRAM <input type="checkbox"/> SMALL BOWEL <input type="checkbox"/> UPPER GI <input type="checkbox"/> OTHER _____ <b>GENITOURINARY</b> <input type="checkbox"/> HSG/HYSTEROALPINGOGRAM <input type="checkbox"/> URETROGRAM <input type="checkbox"/> VCUG <input type="checkbox"/> IVP W/CT CUTS (SUNTREE/OAKS) <input type="checkbox"/> OTHER _____ <b>NUCLEAR MEDICINE</b> <input type="checkbox"/> BILIARY/HIDA W/CCK <input type="checkbox"/> BILIARY/HIDA <input type="checkbox"/> BONE (WHOLE BODY) <input type="checkbox"/> BONE (3 PHASE) <b>SPECIFY</b> _____ <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 _____ <b>SPECIAL PROCEDURES</b> <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 \*

## 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, DIALYSIS)
- ALL MRA CONTRAST STUDIES

### CT:

#### ALL CT STUDIES W/ CONTRAST

- OVER AGE 70
- KIDNEY DISEASE HISTORY
- DIABETIC
- ALL CTA's

### NOTHING TO EAT 4 HOURS PRIOR TO PROCEDURE:

- ALL CAT SCANS REQUIRING  
CONTRAST MEDIA
- ARTHOGRAMS
- 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)

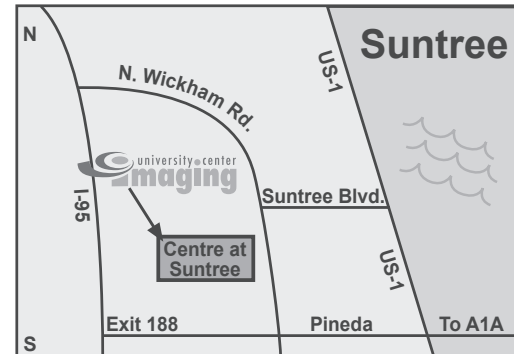
*\* Call facility or visit us online for more  
detailed prep instructions or to confirm  
facility location for appointment.*



Scheduling: (321) 726-3838

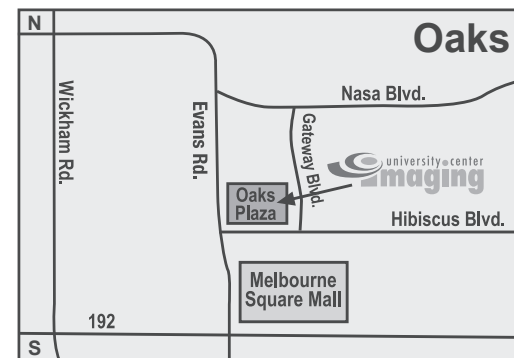
Fax: (321) 726-3842

Info Line: (321) 726-3800



## 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

