ARCADIA RADIOLOGY
MEDICAL GROUP

612 West Duarte Road, Suite 101, Arcadia, CA 91007
Scheduling (626) 445-4850 Fax (626) 821-3460
www.ArcadiaRadiology.com

STAT
- ☐ Stat Appointment & Call Dr. With Results At: ____________
- ☐ Report Only Fax: ____________

IMPORTANT: BRING THIS FORM WITH YOU TO YOUR APPOINTMENT

Patient Name: ______________________ (First / Middle / Last) **DOB:** __________ **Appt: Date:** __________ **Time:** __________

SIGNS/SYMPTOMS: ☐ ACUTE ☐ CHRONIC **Authorization #:** ____________ **CC Physician:** ____________

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MRI

For IV contrast exams, creatinine levels are required for all patients:
- Age 60 or older
- Diabetic
- History of kidney problems or renal failure

☐ Brain ☐ Spine ☐ C ☐ T ☐ L
☐ Brain Spectroscopy ☐ Soft Tissue Neck
☐ IAC's - 7th & 8th Nerve ☐ Abdomen ____________
☐ Pituitary/Sella ☐ Orbits ☐ Pelvis ☐ TMJ
☐ Extremity ____________ R L

MRA

☐ Brain ☐ Carotid Arteries
☐ Aorta - Specify: ☐ Thoracic ☐ Abdominal ☐ Iliac Arteries
☐ Runoff (Abd., Aorta, Lwr. Ext.) ☐ Renal

Breast MRI
☐ Unilateral - R L ☐ Bilateral

Other (Specify) ____________

ARTHROGRAM

☐ MRI ☐ CT

Specify ____________

CT

For IV contrast exams, creatinine levels are required for all patients:
- Age 60 or older
- Diabetic
- History of kidney problems or renal failure

☐ 3D Recon (If Necessary)

☐ Brain ☐ Chest ☐ Spine ☐ C ☐ T ☐ L
☐ Orbits ☐ Chest (HRCT - For Interstitial Lung Disease)
☐ Sinuses ☐ Abdomen ☐ Soft Tissue Neck
☐ Insta Trak Sinus ☐ Temporal Bones ☐ Pelvis
☐ Renal ☐ Coronary Calcium Scoring (CCS)
☐ Biopsy/Epidural ____________ Pre-approval by Radiologist needed
☐ Extremity ____________

CTA

☐ Brain ☐ Carotid Arteries ☐ Pulmonary
☐ Aorta - Specify: ☐ Thoracic ☐ Abdominal ☐ Iliac Arteries
☐ Runoff (Abd., Aorta, Lwr. Ext.) ☐ Renal

☐ **Cardiac CTA**

Other (Specify) ____________

PHYSICIAN SIGNATURE ____________

Date ____________

Arcadia Women's
IMAGING CENTER

622 West Duarte Road, Suite 104, Arcadia, CA 91007
Scheduling (626) 821-8146

DIGITAL MAMMOGRAPHY & ULTRASOUND

Mammogram: ☐ Screening ☐ Diagnostic R L
Ultrasound: ☐ Breast R L ☐ Pelvic ☐ OB
Biopsy: ☐ Breast R L ☐ Thyroid

ULTRASOUND

☐ Carotid Arteries ☐ OB ☐ Pelvic ☐ Transvaginal
☐ Aorta ☐ Thyroid ☐ Prostate ☐ Testicular
☐ Abdomen ☐ Renal (Kidneys/Bladder)
☐ Arterial ____________ ☐ Venous ____________

Other (Specify) ____________

X-RAY

☐ **Complete** ☐ **Limited**

☐ Pelvis ☐ Ribs ☐ Abdominal Series
☐ Chest ☐ 1v ☐ 2v ☐ Scoliosis Series
☐ Sinuses ☐ KUB ☐ Spine ☐ C ☐ T ☐ L
☐ Extremity ____________ R L

Other (Specify) ____________

FLUOROSCOPY

☐ Esophagram ☐ Hysterosalpingogram
☐ Upper GI Series ☐ Barium Enema
☐ Small Bowel Series ☐ IVP

Other (Specify) ____________

BONE DENSITOMETRY

☐ DEXA
☐ QCT

PRINT OR OFFICE STAMP

Physician
Phone
Fax

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