Date of Request: ______________________

Requesting Physician: ______________________

Scheduling Contact: ______________________

Physician Phone: ______________________

Physician Fax: ______________________

Patient Information

Name: ______________________ DOB: ______________

Home Phone: ______________ Cell Phone: ______________ Weight: ______________

See bottom of form for requested information to be faxed to 318.603.5461 Height: ______________

MRI

Dx Code: ______________

Description: ______________________

____ MRI Brain
____ MRI Thoracic Spine
____ MRI Lumbar Spine
____ MRI Abdomen**
____ MRI Prostate** (see dashed-line box below)
____ MRI Pelvis**
____ MRI Kidney**
____ MRI Bladder**
____ MRI Knee
____ MRI Ankle
____ MRI Foot
____ MRI Shoulder
____ MRI Elbow
____ MRI Hand
____ MRI Wrist
____ MRCP**
____ MRA Brain
____ MRA Renal**

Any back surgery on area of spine ordered? ___Yes ___No
Does patient have a pacemaker? ___Yes ___No
Does patient have brain aneurysm clips? ___Yes ___No

____With Contrast ____Without Contrast ____With & Without

CT

Dx Code: ______________

Description: ______________________

____ CT Brain
____ CT Sinus
____ CT Neck (soft tissue)
____ CT Cervical Spine
____ CT Thoracic Spine
____ CT Lumbar Spine
____ CT Chest
____ CT Abdomen/Pelvis**
____ CT Pelvis**
____ CT Abdomen**
____ CTA Abdomen**
____ CT Other (Please specify)

____

Oral Contrast Administration needed?
(For Abdomen/Pelvis and Abdomen scans only)
___ Yes ___ No

____With Contrast ____Without Contrast ____With & Without

Please provide the following if available: (for MRI Prostate scans only) Most recent PSA score: _________ Gleason score: _______
Previous MRI? ___Yes ___No Last MRI date: ____________ Active surveillance? ___Yes ___No

Contrast Details

Complete this entire box if the patient is receiving contrast.

Hx of Hypertension? ___Yes ___No
Hx of Diabetes? ___Yes ___No
Hx of Renal / Kidney Disease? ___Yes ___No

Hx of hepatic disease, liver transplant or pending liver transplant? ___Yes ___No
If answered yes to any question in this box, creatinine level from the last 30 days required: _____MG/DL

All patients over 50 years of age, regardless of renal history, must have a creatinine within 30 days of contrasted CT scan.

All results are faxed to the number provided at the top of this form within 1-2 business days, or sooner. If you would like the results faxed to a different number, please provide it: ______________

____
Physician Signature

Please fax demographic information, insurance information, and this form to 318.603.5461.
If you would like our office to preauthorize this request, please provide the last office note and any recent completed radiology.
If you have already preauthorized this request, please fax the authorization information.
**See back for pre-study instructions

Fax Referrals to: 318.603.5461
For Scheduling Call: 318.683.0411 Ext.460

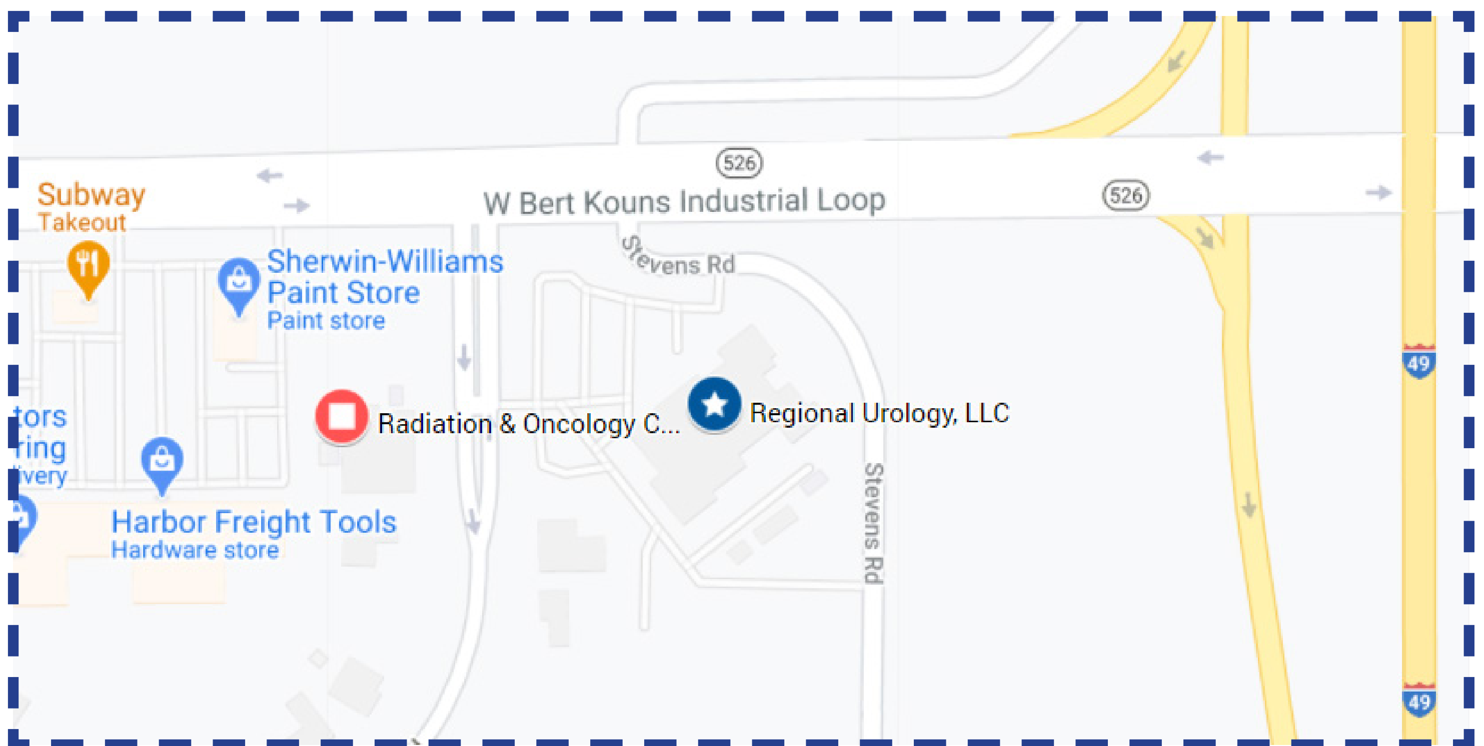
Special Instructions

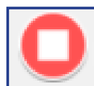
Please arrive 30 minutes prior to your scan for check-in and preparations. All copays and deductables are due at check-in.

All Abdominal Scans:

- -NPO and no caffeine for 4 hours prior to exam
- -Light dinner evening before exam
- -If patient has previously had a prostate biopsy, MRI must be 6 weeks post biopsy, at minimum.

Thank you for letting us care for you!





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301 Bert Kouns Ind. Loop
Shreveport, LA 71106
318-683-0411 ext.300

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