



East Montgomery Imaging Center
6880 Winton Blount Blvd
Montgomery, AL 36117
PHONE: 334-277-1210
FAX: 334-277-1781
FAX: 334-277-1454

for EMIC use only

PATIENT INFORMATION

Patient's Full Name Yinsheng Li DOB 11/31/96 Patient Phone: _____
Ordering Physician Carol Stewart CRNP Office Phone 334 244 3381 Office Fax 334 244 3396
Physician Signature/Date/Time [Signature] Cell Phone Number _____
Reason for Exam (DIAGNOSIS) ⊕ TB skin test

SPECIAL INSTRUCTIONS

- ☐ STAT call # _____ ☐ STAT fax # _____ ☐ Send CD ☐ Send patient back to office
☐ EMIC to schedule ☐ EMIC to precertify exam ☐ Appt Date / Time _____
☐ Obtain i-Stat Creatinine prior to intravenous contrast administration (criteria on reverse side)

CT (Computerized Tomography)

- | | |
|---|--|
| ☐ Brain W/O Contrast | ☐ IAC's (Temporal Bone) |
| ☐ Brain W/O & W Contrast | ☐ Orbits |
| ☐ Sinus W/O | ☐ Soft Tissue Neck W |
| ☐ Chest W/O | ☐ Chest W |
| ☐ Abdomen W and Pelvis W (Routine) | |
| ☐ Abdomen/Pelvis W/O (Stone Hunt) | |
| ☐ Abdomen/Pelvis W/O & W (Hematuria Protocol) | |
| ☐ Abdomen W/O | ☐ Abdomen W/O & W |
| ☐ Pelvis W/O | ☐ Pelvis W |
| ☐ Cervical Spine ☐ W/O ☐ W | ☐ Bony Pelvis |
| ☐ Lumbar Spine ☐ W/O ☐ W | ☐ Other _____ |
| ☐ Thoracic Spine ☐ W/O ☐ W | ☐ 3-D Reconstruction |

CTA (CT Angiography)

- | | |
|--|---|
| ☐ CTA Brain (COW) | ☐ CTA Neck |
| ☐ CTA Abdominal Aorta | ☐ CTA Renals |
| ☐ CTA Pelvis | ☐ CTA Runoff-Bil Lwr Ext |
| ☐ CTA Chest (PE) | ☐ CTA Thoracic Aorta |

MRI (Magnetic Resonance Imaging)

- CONTRAST** W/O _____ W&W/O _____
- | | |
|---|---|
| ☐ Brain | ☐ MRCP (NPO 6hrs) |
| ☐ IAC's | ☐ Kidney |
| ☐ Pituitary | ☐ Liver |
| ☐ Orbits | ☐ Adrenals |
| ☐ Chest Wall | ☐ Hip ☐ R ☐ L ☐ Bilat |
| ☐ Brachial Plexus ☐ R ☐ L ☐ Bilat | ☐ Foot ☐ R ☐ L ☐ Bilat |
| ☐ Pelvis | ☐ Knee ☐ R ☐ L ☐ Bilat |
| ☐ Cervical Spine | ☐ Ankle ☐ R ☐ L ☐ Bilat |
| ☐ Lumbar Spine | ☐ Wrist ☐ R ☐ L ☐ Bilat |
| ☐ Thoracic Spine | ☐ Other _____ |
| ☐ Shoulder ☐ with arthrogram | ☐ R ☐ L ☐ Bilat |

MRA ANGIOGRAPHY

- | | |
|--|---|
| ☐ Intracranial - Circle of Willis | ☐ Renal Arteries |
| ☐ Carotids and Vertebrales | ☐ Other _____ |

FLUOROSCOPY

- | | |
|---|--|
| ☐ GI Series | ☐ BE |
| ☐ GI and Small Bowel | ☐ BE Air Contrast |
| ☐ Small Bowel | ☐ IVP |
| ☐ Esophagram | ☐ Other _____ |

NUCLEAR MEDICINE

- | | |
|--|---------------------------------------|
| ☐ Bone Scan Whole Body | ☐ Renal |
| ☐ Three Phase Bone Scan | ☐ MUGA |
| ☐ Thyroid (uptake and scan) | ☐ Liver/Spleen |
| ☐ Hepatobiliary Scan (HIDA) | ☐ Parathyroid |
| ☐ Gastric Emptying | ☐ Other _____ |

ULTRASOUND

- | | |
|--|--|
| ☐ Obstetrical | ☐ Pelvic |
| ☐ Pelvic/Transvaginal | ☐ Scrotum |
| ☐ Abdomen Complete | ☐ Abdomen (RUQ) |
| ☐ Thyroid | ☐ Hysterosonogram |
| ☐ Renal arteries | ☐ Renal / Kidney |
| ☐ Carotid | ☐ Aorta |
| ☐ Venous Doppler lower extremity | ☐ R ☐ L ☐ Bilat |
| ☐ Venous Doppler upper extremity | ☐ R ☐ L ☐ Bilat |
| ☐ Arterial Doppler lower extremity w/ segmental pressures | |
| ☐ Infant Spine | |
| ☐ Other _____ | |

ROUTINE X-RAYS

- | | |
|---|---|
| ☒ Chest | ☐ Cervical Spine |
| ☐ Abdomen Series | ☐ Thoracic Spine |
| ☐ Ribs ☐ LT ☐ RT | ☐ Lumbar Spine |
| ☐ KUB | ☐ Sinuses |
| ☐ Skull | ☐ Pelvis |
| ☐ Thoracolumbar (Scoliosis) | ☐ Other _____ |
| ☐ Extremity (specify) _____ | ☐ LT ☐ RT |

BONE DENSITY

- ☐ Bone Dexa Axial Skeleton

ADDITIONAL INFORMATION

Please see reverse side for exam preparations

Immunization (Vaccination) Form

To ensure the health and safety of our campus, immunizations against communicable diseases are extremely important. Vaccination against Measles, Mumps, Rubella (MMR) and Tetanus, Diphtheria and Pertussis is required of all students entering Auburn University at Montgomery. This form must be completed and is the preferred document for proof of immunizations. Take this form to a doctor or clinic to be completed. Also, upon arrival to the campus, international students will be required to report to Student Health Services to receive a Tuberculosis Skin Test. The cost of this test is \$10.00. TB skin tests performed outside of the United States will not be accepted.

Name LI YINSHENG AUM Student Number 500342939
 Last First Middle

Local Address 7430 East Drive Montgomery AUM
 Street City State Zip Code

Cell Phone Number _____ E-mail Address 742995219@qq.com Date of Birth (MMDD/YYYY) 01/31/1996

REQUIRED IMMUNIZATIONS (Vaccinations)

Tetanus, Diphtheria, Pertussis Vaccine (preferred vaccine should have one dose prior to entrance)

Date of Tdap vaccine: / /
 D M Y

Measles, Mumps, Rubella (MMR) 2 separate vaccines required.

Auburn Montgomery University requires that all students receive MMR vaccine (MMR) prior to registration. One dose must be received. Mumps and Rubella are acceptable. Please attach proof of vaccination.

Date of First Dose / /
 D M Y

if a Tdap vaccine is accepted.

part is

is containing Measles,

Y

OPTIONAL IMMUNIZATIONS (These immunizations are recommended by the American College Health Association.)

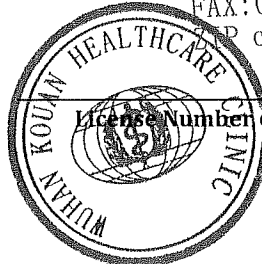
Hepatitis B: / / 07/03/2017 1-HBsAb 1000 U/L
 1st 2nd

Varicella (Chickenpox) Vaccine: / / 07/03/2017 VZV-IgG positive
 1st 2nd

Meningococcal (meningitis) Vaccine: 07/03/2017 / / (MCV4 preferred)
 1st 2nd

I certify that the above dates and vaccinations are true.

Signature of License Health Care professional Huang Xuanchan 07/07/2017 Date
 Huang Xuanchan



No 453, Luoshi Road,
 Hongshan Wuhan, P.R. China
 TEL: 027-59007950
 FAX: 027-59007959
 ZIP code: 430070

8/10/2017

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Li Yinsheng
DATE OF BIRTH 01/31/2017
month day year

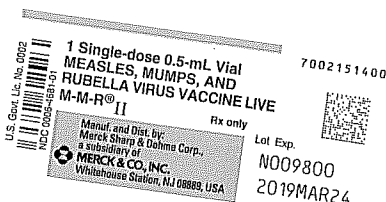
For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Are you sick today?	☐	☒	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☒	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☒	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☒	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☒	☐
6. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☒	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☒	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☒	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☒	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☒	☐

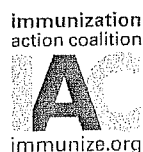
FORM COMPLETED BY Li Yinsheng DATE 15/08/2017
FORM REVIEWED BY [Signature] DATE 8/15/17

Did you bring your immunization record card with you? yes ☒ no ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.



Adacel® NDC 40281-400-58
(L) C5243BA
(E) 26 JUL 2019



Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

Technical content reviewed by the Centers for Disease Control and Prevention

www.immunize.org/catg.d/p4065.pdf • Item #P4065 (10/16)

Yisheng Li

其他疫苗接种证明/CERTIFICATE OF OTHER VACCINATIONS

疫苗或预防措施/Vaccine or prophylaxis

麻腮风/MMR

皮下注射/SC

日期
Date

2017年07月03日

03 Jul, 2017

主管临床医师的签名和专业状况
Signature and professional status
of supervising clinician

内科医师/Physician

接种机构的印章
Official stamp
of administering center



疫苗或预防制品的生产厂商批号
Manufacturer and batch No.
of vaccine or prophylaxis

北京天坛生物制品有限公司
201611106

接种剂量

Vaccination dose

0.5ml

证书有效期 从

Certificate valid. From

至

until

疫苗或预防措施/Vaccine or prophylaxis

流脑A、C、Y、W135/Meningiti 皮下注射/SC

日期
Date

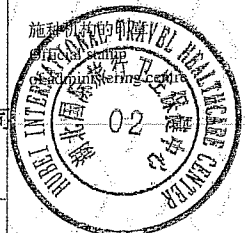
2017年07月03日

03 Jul, 2017

主管临床医师的签名和专业状况
Signature and professional status
of supervising clinician

内科医师/Physician

接种机构的印章
Official stamp
of administering center



疫苗或预防制品的生产厂商批号
Manufacturer and batch No.
of vaccine or prophylaxis

北京智飞绿竹生物制药有限公司
201608020

接种剂量

Vaccination dose

0.5ml

证书有效期 从

Certificate valid. From

至

until