

AUM STUDENT HEALTH CENTER - EMPLOYEES

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: 12-7-18 Are you an AUM Student? ☐ Yes ☒ No S-Number: _____

Name: Jessie Braswell Birthdate: 10-8-73

Main Phone Number: (334) 538-4184 Alternate Phone Number: _____

Local Mailing Address: 7320 Glenview Court Box or APT #: _____

City: Montgomery State: AL Zip Code: 36117

Permanent/Home Address: SAA Box or APT #: _____

City: _____ State: _____ Zip Code: _____

Marital Status (Please Circle): Single Married Divorced Widowed Other: _____

Sex (Please Circle): Male Female Gender: Male Female

Primary Physician: Dr. Tarantino City: Montgomery Phone #: (334) 272-0000

Patient's Employer: Aum Police Officer Work Phone #: 204-3424

Parent's or Spouse's Name (Circle which): Mary Owens Phone #: (334) 649-4350

Parent's or Spouse's Employer: WIA Phone #: _____

Emergency Contact: (334) 649-4350 Relationship: Mother Phone #: _____

How did you hear about the clinic (Circle which): Friend Faculty/Staff Orientation Other: _____

INSURANCE INFORMATION

Do you have health insurance? ☐ YES ☐ NO

If yes, please give your card to the front desk in order for a copy to be made for your chart.

Insurance Company: _____ Name on Card: _____

Policy or Contract Number: _____ Group Number: _____

Insurance Company's Address: _____

AUM STUDENT HEALTH CENTER

CONSENT FOR SERVICES FORM

Patient Name: Janice Braswell Date of Birth: 10 / 8 / 73
Day Month Year

General Consent for Treatment

I request and authorize health care services by my provider and his/her designees(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, laboratory procedures, and administration.

I understand that excluding emergency or extraordinary circumstances, no substantial procedure will be performed without providing me an opportunity to give me informed consent for that procedure. Informed consent means that the medical provider must disclose information to me including benefits and risks of a particular procedure and/or treatment.

Payment

I am responsible for all bills incurred at the Student Health Center. Payment is due at the time that services are rendered unless prior arrangements have been made.

I have read the consent form, or it has been read to me, and I am satisfied that I understand its contents. My questions have been answered to my satisfaction.

Janice Braswell
Signature of Patient

12 / 7 / 18
Day Month Year
Date of Signature

Signature of Legal Representative (if patient is unable to sign)

Relationship to Patient

AUM Student Health Services
Medical Information Release Form
(HIPPA Release Form)

Name: Janice Braswell Date of Birth 10/8/73

Release of Information

☐ I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may be released to:

☐ Spouse: _____

☒ Child(ren): Kywasi Braswell

☒ Other: Dr.

☐ Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☐ my cell number: (384) - 538 - 4184

If unable to reach me:

☒ you may leave me a detailed message

☐ please leave a message asking me to return your call

☐ other: _____

The best time to reach me is (day or days) Anytime between _____ and _____ times.

Signed: Janice Braswell

Date: 12/7/18

AUM Student Health Services

PATIENT HIPPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involve in my treatment)
- Obtaining payment from third party payers (e. g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your *Summary of the HIPPA Privacy Rule*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree with these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this 7 day of 12 2018.
(day) (month) (last two digits of the year)

Print Patient's Name: Danice Braswell

Signature: Danice Braswell

Relationship to Patient (if you are the patient, write "self"): _____

[Home](#) [Resources](#) [Patient & Claim](#) [Payment & Refund](#) [Profiles & Reports](#)[prior authorization](#)

RESOURCES

[EDUCATION & EVENTS](#)[ENROLLMENT & CREDENTIALING](#)[FORMS & MANUALS](#)[PHARMACY](#)[POLICIES & GUIDELINES](#)[PROGRAMS & INITIATIVES](#)[PROVIDER eSOLUTIONS](#)[PROVIDER NETWORKS](#)

Search Results

PRECERTIFICATION OF ADVANCED IMAGING SERVICES

Blue Cross and Blue Shield of Alabama network referring providers are required to obtain a precertification from eviCore (formerly known as CareCore National) for the following services prior to scheduling PET scans, CT scans, CTA scans, MRI tests and MRA tests.

PROVIDER-ADMINISTERED DRUG REVIEW PROGRAM (EXCLUDING ONCOLOGY)

Blue Cross and Blue Shield of Alabama offers a new paperless predetermination service* that will streamline the authorization process for medical drugs (also known as provider-administered drugs).

PET, MRI, MRA, CT, CTA/CCTA

FINAL SELF-ADMINISTERED DRUG POLICIES

DRAFT SELF-ADMINISTERED DRUG POLICIES

To ensure that the development of Blue Cross and Blue Shield of Alabama pharmacy policies occurs through an open, collaborative process, we welcome physicians and other providers to submit comments about pharmacy policies that are in the draft stage. We accept comments for 45 days from the posting date listed on the draft policy. Our current draft policies are listed below.

CATEGORICAL LISTING OF FORMS

MEDICARE PART D, BLUE ADVANTAGE AND BLUERX

PHARMACY RESOURCES

Pharmacy Resources for Healthcare Providers

SELF-ADMINISTERED DRUG POLICIES

Final Self-Administered Drug Policies

OPIOID MANAGEMENT STRATEGY

RADIATION THERAPY MANAGEMENT

MEDICAL POLICY AND PRECERTIFICATION INFORMATION FOR OUT-OF-AREA MEMBERS

NEW SHINGLES VACCINATION

PREFERRED RADIOLOGY PROGRAM

Blue Cross and Blue Shield of Alabama's Preferred Radiology Program (PRP) supports referring physicians in their decision-making process, promotes patient safety by voiding duplication of diagnostic services, maximizes customer benefits by providing the most current clinical and technical recommendations to radiology providers, and minimizes patient out-of-pocket costs by directing patients to a diagnostic facility participating in the Blue Cross network.

HIPAA PRIVACY AND NON-FILED CLAIMS

In order to comply with HIPAA regulations, Blue Cross has a policy regarding claims that members do not want to be filed.

[Show More Results](#)

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CDT codes, descriptions and data copyright ©2017 American Dental Association. All rights reserved.

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CHAIN OF CUSTODY FORM



0131783664

SPECIMEN ID NO.

0131783664

LAB ACCESSION NO.

STEP 1: TO BE COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address and I.D. No.

B. MRO Name, Address, Phone and Fax No.

424027

C. Donor SSN or Employee I.D. No.

D. Reason for Test: ☐ Pre-Employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Periodic ☐ Other

E. Collection Site Address:

Collector Phone No.

Collector Fax No.

F. Donor Identification Verified By: ☒ Photo I.D. ☐ Employer Representative

STEP 2: TO BE COMPLETED BY COLLECTOR

Read specimen temperature within 4 minutes. Is temperature between 90° and 100°F? ☐ Yes ☐ No, Enter Remark Below Split Specimen Collection ☒ Yes ☐ No

REMARKS:

STEP 3: TO BE COMPLETED BY COLLECTOR AND DONOR - Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s).

STEP 4: TO BE COMPLETED BY COLLECTOR AND DONOR

G. Daytime Phone No. ()

Evening Phone No. ()

Date of Birth / /

H. TEST(S) REQUESTED BY EMPLOYER:

I authorize the collection of this specimen for the purpose of a drug screen. I acknowledge that the specimen container(s) was/were sealed with tamper-proof seal(s) in my presence; and that the information provided on this form and on the label(s) affixed to the specimen container(s) is correct. I authorize the laboratory to release the results of the test to the company identified on this form or its designated agents.

(PRINT) DONOR'S NAME (FIRST, MI, LAST)

SIGNATURE OF DONOR

MONTH

DAY

YEAR

STEP 5: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY LABORATORY

I certify that the specimen given to me by the donor identified on this form was collected, labeled, sealed, and released to the Delivery Service noted in accordance with applicable requirements.

SPECIMEN BOTTLE(S) RELEASED TO:

Primary Specimen Bottle Seal Intact

☐ Yes☐ No, Enter Remark Below

SPECIMEN BOTTLE(S) RELEASED TO:

RECEIVED AT LAB:

Signature of Accessioner

(PRINT) Accessioner's Name (First, MI, Last)

Date (Mo/Day/Yr.)

NAME: _____ Date: _____

AUM Student Health Services Comprehensive Health History Form

Medical History: Do you have, or have you ever had any of the following? (check all that apply)

Cardiovascular ☒ High Blood Pressure ☐ Congestive Heart Failure ☐ Atrial Fibrillation ☐ Other: _____	Gastrointestinal ☐ Ulcers ☐ Pancreatitis ☐ Irritable Bowel ☐ Colitis ☐ Crohn's ☒ Reflux	Respiratory ☐ Asthma ☐ COPD / Emphysema ☐ TB (Tuberculosis)	Immunologic / Viral ☐ HIV / AIDS ☐ Herpes ☐ Epstein-Barr	Endocrine ☐ Diabetes ☐ Thyroid (Hyper/Hypo) Musculoskeletal ☐ Arthritis
Neurologic ☐ Stroke ☐ Parkinson's Disease ☐ Alzheimer's / Dementia ☐ Seizure Disorder ☐ Headaches ☐ Migraines ☐ Sleep Apnea ☐ Fibromyalgia ☐ Insomnia (Can't Sleep)	Kidney & Urologic ☐ Kidney Stones ☐ Enlarged Prostate ☐ Urinary Tract Infections Liver ☐ Gallstones ☐ Cirrhosis Hepatitis: ☐ A ☐ B ☐ C	Reproductive ☒ Hysterectomy ☐ Contraceptives Used: Menstrual Cycle: ☐ Regular ☐ Irregular ☐ Genital Disease(s) ☐ Infertility ☐ Erectile Dysfunction	Ear/Nose/Throat/Eye ☐ Glaucoma ☐ Cataract ☐ Chronic Sinus Infection ☐ Upper Airway Infections ☐ Dizziness	Other ☐ Cancer (explain): ☐ Anemia ☐ High Cholesterol ☐ Sickle Cell ☐ On Anticoagulants ☐ Chronic Pain (explain): ☐ Skin Conditions (explain):

Review of Systems: (check all SYMPTOMS that apply)

Systemic Weight: ☐ gain ☐ loss ☐ Fever ☐ Chills ☐ Night Sweats ☐ Pain	Gastrointestinal Appetite: ☐ good ☐ fair ☐ poor ☐ Difficulty Swallowing ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Heartburn ☐ Rectal Bleeding ☐ Abdominal Pain	Cardiovascular ☐ Chest Pain ☐ Palpitations (irregular heartbeat)	Skin ☐ Dry Skin ☐ Itchy Skin ☐ Peeling Skin ☐ Scaling Skin ☐ Discolored Skin ☐ Rash(es) on Skin	Endocrine ☐ Excessive Thirst ☐ Heat Intolerance ☐ Cold Intolerance ☐ Excessive Sweating ☐ Feelings of Weakness
Neurologic / Head ☐ Involuntary Movements ☐ Speech Problems ☐ Paralysis ☐ Dizziness ☐ Fainting ☐ Vertigo ☐ Confusion ☐ Memory Loss ☐ Limb Weakness ☐ Balance Problems ☐ Tingling ☐ Numbness ☐ Headache ☐ Sinus Pain	Genitourinary ☐ Blood in Urine ☐ Odor in Urine ☐ Frequent Urination ☐ Difficult Urination ☐ Small Amount of Urine ☐ Night Time Urination ☐ Incontinent of Urine	Pulmonary ☐ Difficulty Breathing ☐ Short of Breath ☐ Dry Cough ☐ Productive Cough ☐ Cough with Blood ☐ Wheezing	Eye and Ears-Nose-Throat ☐ Vision ☐ Diplopia ☐ Blurry Vision ☐ Red Eyes ☐ Hearing Loss ☐ Tinnitus (ringing in ear) ☐ Epistaxis (nose bleeds) ☐ Nasal Itching ☐ Sore Throat ☐ Mouth Sores ☐ Mouth Dryness ☐ Runny Nose	Musculoskeletal ☐ Back Pain ☐ Muscle Aches ☐ Muscle Cramps ☐ Joint Pain - localized ☐ Joint Swelling - localized ☐ Joint Stiffness - localized ☐ Arthritis Pain

Please list all prior surgeries and hospitalizations for medical illnesses:

Do you have any allergies to food or medications? If so, please list below & the type(s) of reaction (ie: hives, tongue swelling, etc.).



INDUSTRIAL MEDICINE WORK STATUS REPORT

Employer: Hubert University of Montana Date: 11/26/18 Time: 1931
Patient Name: Janice Brasswell Date & Time of Injury: 11/26/18 7:00

MEDICAL INFORMATION

Diagnosis: _____

Treatment: _____

Employee may return to work regular duty/no restrictions _____

Work status to be determined at follow-up appointments: _____

Employee may return to work with the following restrictions:

No/Limited Use of:

- ☐ Arm L/R
- ☐ Leg L/R
- ☐ Hand L/R

No Lifting:

- ☐ 5 lbs or more
- ☐ 10 lbs or more
- ☐ 20 lbs or more

No/Limited

- ☐ Sitting
- ☐ Standing
- ☐ Bending

Keep Elevated

- ☐ Leg L/R
- ☐ Foot L/R
- ☐ Arm L/R

Other: ☐ Keep clean & dry ☐ Desk job only ☐ Limited walking

Additional Comments: _____

Physician Signature: _____

Follow-up at:

☐ Silver Hills PriMed
1595 East Main Street
Prattville, AL 36066
Phone: 334-361-3171
Fax: 334-361-3176

☐ Atlanta Highway PriMed
4305 Atlanta Highway
Montgomery, AL 36109
Phone 334-271-7051
Fax: 334-271-7055

Follow-up Appointment Date: _____

*Patients seen in the emergency Department must follow-up at PriMed the following morning at 7AM
(Exception - Saturday or Sunday follow-up patients report at 9AM)

I have read and understand the above instructions. _____

Patient Signature

ER: Please fax Medical Record, Work Status Report and Authorization/Accident Summary to PriMed on date of service.

1st copy — Employee (to give to Employer) 2nd copy — Medical Record 3rd copy — PriMed



INDUSTRIAL MEDICINE

Authorization for Medical Treatment & Accident Summary

To be completed by employer:

Employer: Autism University of Maryland Date & Time: _____

Employer/Business Address: _____

Billing Information (if different from above): _____

Employer Representative(s): Chief HR

Phone Number: 322 1206 Cell/Beeper Number: _____

Please circle below:

Treat Injury: Yes or No Drug Test Yes Yes or No DOT/Federal Yes or No

DOT Breath Alcohol Test Yes or No

Purpose of Test: Post Accident Random Pre-Employment Reasonable Suspicion
Return to Duty Follow-up Other (specify) _____

Authorized Signature & Title: _____

To be completed by Patient/Employee for injury care:

Employee's Name: Autism Job Title: _____

Job at time of accident: _____ Date & Time of accident: _____

Date & Time reported to employer: _____

Nature of injury (include left/right, etc.): Autism

Explain exactly what happened at the time of the accident: _____

What could be done to prevent this type of accident in the future: _____

Employee Signature: Autism

Physician's Comments: _____

Baptist Medical Center East

400 Taylor Road

Montgomery, AL 36117

Emergency Department

Patient Summary

Name: BRASWELL, JANICE D

Current Date: 11/26/18 21:34:51

MRN: E000113400

FIN: E1833001921

Chief Complaint: Closed head injury without LOC; Headache; Fall; FALL

Final Diagnosis:

Emergency Room Primary Provider:

Baptist Medical Center East would like to thank you for allowing us to assist you with your healthcare needs. The following includes patient education materials and information regarding your injury/illness.

Follow-up Instructions:

Return to Emergency Department if symptoms worsen

With:

Address:

When:

Return to Emergency
Department

Comments:

for worsening symptoms or concerns.

With:

Address:

When:

Louisa Tolentino

470 Taylor Rd, Ste 310 Montgomery, Within 2 to 3 Days
Alabama 36117
(334) 244-4322 Business (1)

Comments:

Call for a follow up appointment.

Name BRASWELL, JANICE D

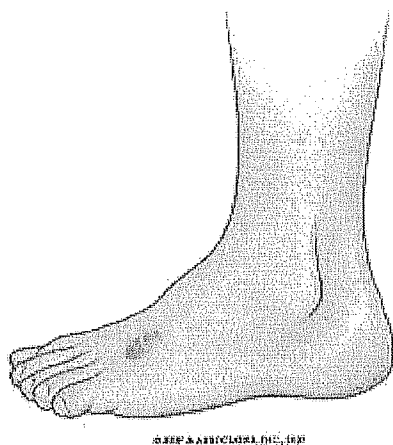
Medication List:

New Medications	AM	Noon	PM	Bed	Special Instructions
methocarbamol (Robaxin-750) 750 mg = 1 Tab By Mouth 3 Times a Day as needed for MUSCLE SPASMS <i>Printed prescription will be given to you</i> Next Dose Due: _____					
naproxen (Anaprox-DS 550 mg) 550 mg = 1 Tab By Mouth Twice Daily as needed for pain <i>Printed prescription will be given to you</i> Next Dose Due: _____					Instructions: TAKE WITH FOOD.

Patient Education Instructions:

Hematoma

A hematoma is a collection of blood. The collection of blood can turn into a hard, painful lump under the skin. Your skin may turn blue or yellow if the hematoma is close to the surface of the skin. Most hematomas get better in a few days to weeks. Some hematomas are serious and need medical care. Hematomas can be very small or very big.

**HOME CARE**

- Apply ice to the injured area:
 - Put ice in a plastic bag.
 - Place a towel between your skin and the bag.
 - Leave the ice on for 20 minutes, 2–3 times a day for the first 1 to 2 days.

Name BRASWELL, JANICE D

Baptist Medical Center East

400 Taylor Road

Montgomery, AL 36117

Emergency Department

Patient Copy

I, BRASWELL, JANICE D, understand that the treatment I have received was rendered on an emergency basis and is not meant to replace complete care from a primary care provider or clinic. Furthermore, I may have been released before all of my medical problems were apparent, diagnosed, and/or treated. If my condition worsens, I have been instructed to call my primary care provider or return to this facility or the nearest emergency center. I understand that I should NOT drive or perform hazardous tasks if my medication or treatment causes drowsiness. I have read and understand the above, received a copy of this form and applicable instruction sheets, and I will arrange for follow-up care. If diagnostic test indicate a need for modification in therapy, you will be notified at the phone number you provided. I have received a list of tests / procedures done during my stay in the Emergency Department and I have been advised to share this list with my Primary Physician. Resume your home medications as reported on your Home Medication Record Sheet, attached here. Do not take any other non-listed medications without first checking with your physician. Take medication list with you to your next physician visit(s). Keep your medication list updated and carry with you at all times in case of emergency.

Tests/Procedures:

Laboratory Orders

No laboratory orders were placed.

Radiology Orders

Name	Status	Details
CT Brain w/o contrast	Ordered	Stat, 11/26/18 20:34:00 CST, Headache, Ambulatory, ONCE
CT Cervical Spine w/o contrast	Ordered	Stat, 11/26/18 20:34:00 CST, Trauma, Ambulatory, ONCE
DX Knee Complete Right	Ordered	Stat, 11/26/18 20:34:00 CST, Pain, Ambulatory, ONCE

Cardiology Orders

Name BRASWELL, JANICE D

- After the first 2 days, switch to using warm packs on the injured area.
- Raise (*elevate*) the injured area to lessen pain and puffiness (*swelling*). You may also wrap the area with an elastic bandage. Make sure the bandage is not wrapped too tight.
- If you have a painful hematoma on your leg or foot, you may use crutches for a couple days.
- Only take medicines as told by your doctor.

GET HELP RIGHT AWAY IF:

- Your pain gets worse.
- Your pain is not controlled with medicine.
- You have a fever.
- Your puffiness gets worse.
- Your skin turns more blue or yellow.
- Your skin over the hematoma breaks or starts bleeding.
- Your hematoma is in your chest or belly (*abdomen*) and you are short of breath, feel weak, or have a change in consciousness.
- Your hematoma is on your scalp and you have a headache that gets worse or a change in alertness or consciousness.

MAKE SURE YOU:

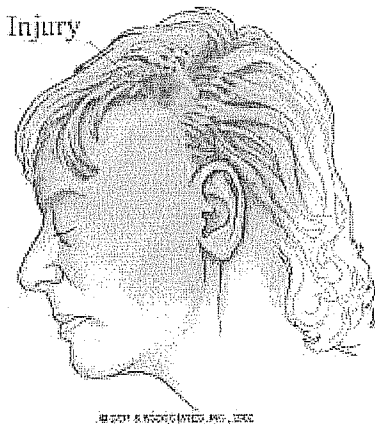
- Understand these instructions.
- Will watch your condition.
- Will get help right away if you are not doing well or get worse.

Document Released: 01/25/2006 Document Revised: 08/20/2014 Document Reviewed: 05/28/2014

ExitCare® Patient Information ©2015 ExitCare, LLC. This information is not intended to replace advice given to you by your health care provider. Make sure you discuss any questions you have with your health care provider.

Head Injury

You have a head injury. Headaches and throwing up (*vomiting*) are common after a head injury. It should be easy to wake up from sleeping. Sometimes you must stay in the hospital. Most problems happen within the first 24 hours. Side effects may occur up to 7–10 days after the injury.



WHAT ARE THE TYPES OF HEAD INJURIES?

Head injuries can be as minor as a bump. Some head injuries can be more severe. More severe head

Name BRASWELL, JANICE D

injuries include:

- A jarring injury to the brain (*concussion*).
- A bruise of the brain (*contusion*). This means there is bleeding in the brain that can cause swelling.
- A cracked skull (*skull fracture*).
- Bleeding in the brain that collects, clots, and forms a bump (*hematoma*).

WHEN SHOULD I GET HELP RIGHT AWAY?

- You are confused or sleepy.
- You cannot be woken up.
- You feel sick to your stomach (*nauseous*) or keep throwing up (*vomiting*).
- Your dizziness or unsteadiness is getting worse.
- You have very bad, lasting headaches that are not helped by medicine. Take medicines only as told by your doctor.
- You cannot use your arms or legs like normal.
- You cannot walk.
- You notice changes in the black spots in the center of the colored part of your eye (*pupil*).
- You have clear or bloody fluid coming from your nose or ears.
- You have trouble seeing.

During the next 24 hours after the injury, you must stay with someone who can watch you. **This person should get help right away (call 911 in the U.S.) if you start to shake and are not able to control it (have seizures), you pass out, or you are unable to wake up.**

HOW CAN I PREVENT A HEAD INJURY IN THE FUTURE?

- Wear seat belts.
- Wear a helmet while bike riding and playing sports like football.
- Stay away from dangerous activities around the house.

WHEN CAN I RETURN TO NORMAL ACTIVITIES AND ATHLETICS?

See your doctor before doing these activities. You should not do normal activities or play contact sports until 1 week after the following symptoms have stopped:

- Headache that does not go away.
- Dizziness.
- Poor attention.
- Confusion.
- Memory problems.
- Sickness to your stomach or throwing up.
- Tiredness.
- Fussiness.
- Bothered by bright lights or loud noises.
- Anxiousness or depression.
- Restless sleep.

MAKE SURE YOU:

- Understand these instructions.
- Will watch your condition.
- Will get help right away if you are not doing well or get worse.

No cardiology orders were placed.

Name BRASWELL, JANICE D

420 111789

Contract # PPA 853013784

Diagnosis → Head trauma

CPT code Hematoma
#A5

CT of Head
5 contrast

DOB - 10/8/1973

N-prox 350mg bid prn #20

Hydroxin 750mg

3x/d-y as needed #15

4-9 years

12-19-18
2020
Epperson

Preparation Instructions:

CT / CTA Scan and IVP Exams

If the patient is having an exam requiring **IV contrast**, please note the following:

1. A light meal or nothing to eat or drink 4 hours prior to the exam.
2. Diabetic patients taking GLUCOPHAGE, GLUCOVANCE, METAFORMIN, AVANDAMET or METAGLIP may not resume this medication for 48 hours after their exam. A Creatinine must be obtained prior to the exam and then re-checked before continuing meds.
3. If the patient is over 50, he or she needs a serum creatinine study within the prior 3 months of exam. **Lab report required.**
4. Please notify if the patient has renal or heart problems.

Nuclear Medicine

- **Thyroid:** Patients must be off thyroid medication and no IV contrast for 4 weeks prior to exam.
- **Gastric Emptying, Hepatobiliary (HIDA):** Nothing to eat or drink for 4-6 hours before exam.

Fluoroscopy

- **Barium Enema (BE), IVP:** Obtain bowel cleansing instructions from us or your physician.
- **Upper GI, Esophagram, Small Bowel:** Nothing to eat or drink after midnight.

MRI

If the patient is having an exam requiring **IV contrast**, please note the following:

A serum creatinine should be obtained if the patient has any of the following risk factors:

1. Age 50 or older.
2. Family history of kidney failure.
3. Diabetes treated with insulin or other medications.
4. Paraproteinemia syndromes or diseases.
5. History of kidney disease as an adult including tumor and transplant.

*A Creatinine level within the prior 6 months is sufficient in most clinical settings. **Lab report required.***

- **MRCP:** Nothing to eat or drink for 4-6 hours

Ultrasound

- **Abdomen:** Nothing to eat or drink for 6 hours prior to exam.
- **Pelvis:** drink 64 oz. of water 1 ½ hour prior to exam. Do not empty bladder before exam.
- **Renal Artery:** Nothing to eat or drink for 8 hours prior to exam.

Directions to East Montgomery Imaging Center

From I-85:

Exit at Taylor Road, AUM. Turn North onto Taylor Road, you will see Baptist East on your left. Pass the hospital and take the next left onto Winton Blount Boulevard. We are located on the left, adjacent to the Baptist Breast Center, across from the Post Office.

From Atlanta Highway:

Turn South onto Taylor Road, headed towards Baptist East. Before you reach the hospital you will turn right onto Winton Blount Boulevard. We are located on the left, adjacent to the Baptist Breast Center, across from the Post Office.

Please have patients bring a list of current medications.

EMIC

East Montgomery
Imaging Center
6880 Winton Blount Boulevard
Montgomery, AL 36117
334-277-1210

