



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 Pamela Dent DOB 8/11/60 Patient Phone: 334-220-0779
Ordering Physician Lindsay Burton, CRNP Office Phone 334-344-3201 Office Fax 334-244-3396
Physician Signature/Date/Time [Signature] Cell Phone Number (334) 714-7180
Reason for Exam/DIAGNOSIS (Required) Cough

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 |

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 | |

MRA ANGIOGRAPHY

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

BONE DENSITY

- ☐ Bone Dexa Axial Skeleton

ADDITIONAL INFORMATION

TRANSMISSION VERIFICATION REPORT

TIME : 07/24/2020 13:42
NAME : AUM
FAX : 3342443396
TEL :
SER.# : BROD8J659256

DATE, TIME	07/24 13:41
FAX NO./NAME	92771781
DURATION	00:01:07
PAGE(S)	02
RESULT	OK
MODE	STANDARD

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Montgomery, AL 36124
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**AUBURN UNIVERSITY
AT MONTGOMERY**

STUDENT HEALTH SERVICES

Attn: EMIC

To:

From: Aum Warhawk Health Services

Fax: 334-277-1781

Pages: 2

Phone: 334-277-1210

Date: 7/24/2020

Re: P. Dent D.O.B. 8/11/60

cc:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Comments:

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