



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

for EMIC use only

### PATIENT INFORMATION

Patient's Full Name Denonna Gray DOB 3/25/61 Patient Phone: \_\_\_\_\_  
Ordering Physician Lindsey Barton, CRNP Office Phone 244-3281 Office Fax (334) 244-3390  
Physician Signature/Date/Time [Signature] 12/31/2011 Cell Phone Number 714-7180  
Reason for Exam/DIAGNOSIS(Required) [Signature] previous DVT to LLE

### SPECIAL INSTRUCTIONS

☐ STAT call # \_\_\_\_\_ ☐ STAT fax # \_\_\_\_\_ ☐ Send CD ☐ Send patient back to office  
☐ EMIC to schedule ☐ EMIC to precertify exam ☒ Appt Date / Time Monday 12/11/21 0930  
☐ Obtain i-Stat Creatinine prior to intravenous contrast administration (criteria on reverse side) PT to call + schedule

### CT (Computerized Tomography)

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

### FLUOROSCOPY

- |                                             |                                          |
|---------------------------------------------|------------------------------------------|
| <input type="checkbox"/> GI Series          | <input type="checkbox"/> BE              |
| <input type="checkbox"/> GI and Small Bowel | <input type="checkbox"/> BE Air Contrast |
| <input type="checkbox"/> Small Bowel        | <input type="checkbox"/> IVP             |
| <input type="checkbox"/> Esophagram         | <input type="checkbox"/> Other _____     |

### NUCLEAR MEDICINE

- |                                                    |                                       |
|----------------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Bone Scan Whole Body      | <input type="checkbox"/> Renal        |
| <input type="checkbox"/> Three Phase Bone Scan     | <input type="checkbox"/> MUGA         |
| <input type="checkbox"/> Thyroid (uptake and scan) | <input type="checkbox"/> Liver/Spleen |
| <input type="checkbox"/> Hepatobiliary Scan (HIDA) | <input type="checkbox"/> Parathyroid  |
| <input type="checkbox"/> Gastric Emptying          | <input type="checkbox"/> Other _____  |

### CTA (CT Angiography)

- |                                              |                                                 |
|----------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> CTA Brain (COW)     | <input type="checkbox"/> CTA Neck               |
| <input type="checkbox"/> CTA Abdominal Aorta | <input type="checkbox"/> CTA Renals             |
| <input type="checkbox"/> CTA Pelvis          | <input type="checkbox"/> CTA Runoff-Bil Lwr Ext |
| <input type="checkbox"/> CTA Chest (PE)      | <input type="checkbox"/> CTA Thoracic Aorta     |

### MRI (Magnetic Resonance Imaging)

- |                                                                                                                               |                                                                                                                     |
|-------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|
| <b>CONTRAST</b> <b>W/O</b> _____ <b>W&amp;W/O</b> _____                                                                       |                                                                                                                     |
| <input type="checkbox"/> Brain <input type="checkbox"/> IAC's                                                                 | <input type="checkbox"/> MRCP (NPO 6hrs)                                                                            |
| <input type="checkbox"/> Pituitary                                                                                            | <input type="checkbox"/> Kidney                                                                                     |
| <input type="checkbox"/> Orbits                                                                                               | <input type="checkbox"/> Liver                                                                                      |
| <input type="checkbox"/> Breast <input type="checkbox"/> w/out <input type="checkbox"/> with <input type="checkbox"/> Bilat   | <input type="checkbox"/> Adrenals                                                                                   |
| <input type="checkbox"/> Chest Wall                                                                                           | <input type="checkbox"/> Hip <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilat   |
| <input type="checkbox"/> Brachial Plexus <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilat | <input type="checkbox"/> Foot <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilat  |
| <input type="checkbox"/> Pelvis                                                                                               | <input type="checkbox"/> Knee <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilat  |
| <input type="checkbox"/> Cervical Spine                                                                                       | <input type="checkbox"/> Ankle <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilat |
| <input type="checkbox"/> Lumbar Spine                                                                                         | <input type="checkbox"/> Wrist <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilat |
| <input type="checkbox"/> Thoracic Spine                                                                                       | <input type="checkbox"/> Other _____                                                                                |
| <input type="checkbox"/> Shoulder <input type="checkbox"/> with arthrogram                                                    | <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilat                                |

### MRA ANGIOGRAPHY

- |                                                          |                                                              |
|----------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Intracranial - Circle of Willis | <input type="checkbox"/> Renal Arteries                      |
| <input type="checkbox"/> Carotids and Vertebrales        | <input type="checkbox"/> Other _____                         |
| <input type="checkbox"/> Runoff - Bilat Lower Ext.       | <input type="checkbox"/> w/out <input type="checkbox"/> with |

### MRV Venography

- |                                |                                 |                                  |                                |
|--------------------------------|---------------------------------|----------------------------------|--------------------------------|
| <input type="checkbox"/> Brain | <input type="checkbox"/> Pelvis | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Other |
|--------------------------------|---------------------------------|----------------------------------|--------------------------------|

### ULTRASOUND

- |                                                                                                                                                                    |                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Obstetrical                                                                                                                               | <input type="checkbox"/> Pelvic          |
| <input type="checkbox"/> Pelvic/Transvaginal                                                                                                                       | <input type="checkbox"/> Scrotum         |
| <input type="checkbox"/> Abdomen Complete                                                                                                                          | <input type="checkbox"/> Abdomen (RUQ)   |
| <input type="checkbox"/> Thyroid                                                                                                                                   | <input type="checkbox"/> Hysterosonogram |
| <input type="checkbox"/> Renal arteries                                                                                                                            | <input type="checkbox"/> Renal / Kidney  |
| <input type="checkbox"/> Carotid                                                                                                                                   | <input type="checkbox"/> Aorta           |
| <input checked="" type="checkbox"/> Venous Doppler lower extremity <input type="checkbox"/> R <input checked="" type="checkbox"/> L <input type="checkbox"/> Bilat |                                          |
| <input type="checkbox"/> Venous Doppler upper extremity <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilat                       |                                          |
| <input type="checkbox"/> Arterial Doppler lower extremity w/ segmental pressures                                                                                   |                                          |
| <input type="checkbox"/> Infant Spine                                                                                                                              |                                          |
| <input type="checkbox"/> Other _____                                                                                                                               |                                          |

### ROUTINE X-RAYS

- |                                                                                       |                                                         |
|---------------------------------------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Chest                                                        | <input type="checkbox"/> Cervical Spine                 |
| <input type="checkbox"/> Abdomen Series                                               | <input type="checkbox"/> Thoracic Spine                 |
| <input type="checkbox"/> Ribs <input type="checkbox"/> LT <input type="checkbox"/> RT | <input type="checkbox"/> Lumbar Spine                   |
| <input type="checkbox"/> KUB                                                          | <input type="checkbox"/> Sinuses                        |
| <input type="checkbox"/> Skull                                                        | <input type="checkbox"/> Pelvis                         |
| <input type="checkbox"/> Thoracolumbar (Scoliosis)                                    | <input type="checkbox"/> Other _____                    |
| <input type="checkbox"/> Extremity (specify) _____                                    | <input type="checkbox"/> LT <input type="checkbox"/> RT |

### BONE DENSITY

- |                                                   |
|---------------------------------------------------|
| <input type="checkbox"/> Bone Dexa Axial Skeleton |
|---------------------------------------------------|

### ADDITIONAL INFORMATION