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Scheduling: 713-592-9800














Patient Name	DOB	SSN
Patient Phone #	Insurance	
Referring Physician	Phone	Fax
Diagnosis	Allergies	
Appointment Date and Time		

W/O Contrast
 W/Contrast
 W/WO Contrast

Special instructions or comments _____

Please have patient bring in any prior films.

- STAT Order
 Verbal Report
 Fax Report

Upright/Weight-Bearing		Recumbent Only	
 <p>Brain</p> <input type="checkbox"/> Routine <input type="checkbox"/> TMJ <input type="checkbox"/> Posteria Fossa <input type="checkbox"/> Sinuses <input type="checkbox"/> IAC'S <input type="checkbox"/> Pituitary <input type="checkbox"/> Orbits	<p>MRA</p> <input type="checkbox"/> Circle of Willis <input type="checkbox"/> Carotid Arteries	 <p> <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Prostate <input type="checkbox"/> Brain (Specify) _____ <input type="checkbox"/> Spine (Specify) _____ <input type="checkbox"/> Joints (Specify) _____ <input type="checkbox"/> Other (Specify) _____ </p>	
 <p>Spine</p> <input type="checkbox"/> Cervical - specify below <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbosacral - specify below		<p>Cervical</p>  <input type="checkbox"/> Neutral Upright  <input type="checkbox"/> Flexion Upright  <input type="checkbox"/> Extension Upright  <input type="checkbox"/> Lateral Bending Upright	
 <p>Joints</p> <input type="checkbox"/> Hip <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Knee <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Ankle <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Shoulder <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Elbow <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Wrist <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Gaiting (for lower extremity joints)		<p>Perform recumbent scan for comparison? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> L <input type="checkbox"/> R</p>	
 <p>Miscellaneous</p> <input type="checkbox"/> Chest <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Breast <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Prostate Other: _____ _____ _____		<p>Lumbosacral</p>  <input type="checkbox"/> Neutral Upright  <input type="checkbox"/> Flexion Upright  <input type="checkbox"/> Extension Upright  <input type="checkbox"/> Lateral Bending Upright	
<p>Perform recumbent scan for comparison? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		<p>Physician's signature _____ Date _____</p>	