

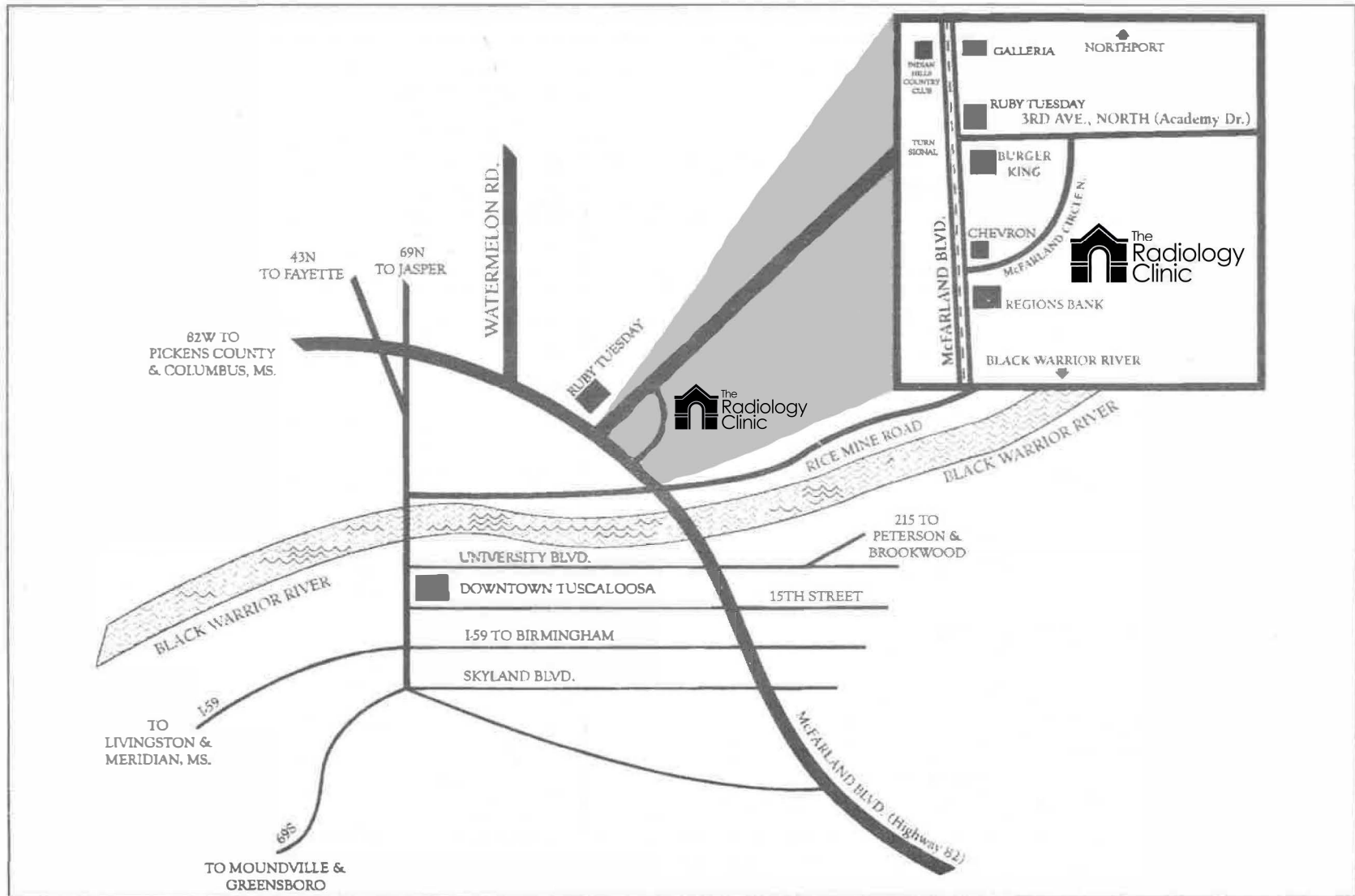


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 tuscaloosaradiology.com

Patient Name: _____ DOB: _____ Date: _____
 Appointment Date: _____ Time: _____
 Provider's Signature: _____ MD / DO / DC / OD / CRNP / PA (Stamped Signatures are not acceptable)
 Provider's Name (PRINTED): _____ CDS # (if Medicare patient): _____
 CDS Mechanism Used: _____ Modifier _____

GENERAL	Prep Instructions:	CT	Prep Instructions:
<input type="checkbox"/> Chest X-Ray	No prep	<input type="checkbox"/> CTA's: Head / Neck / Abd / Abd/Pelvis / Aorta w/Runoff	Clear liquid diet 4 hours prior to exam (no oral prep)
<input type="checkbox"/> Other Body Part X-Ray *specify below*		<input type="checkbox"/> CTA Chest <input type="checkbox"/> CTA Chest for PTE <input type="checkbox"/> CT Chest w/cont	Clear liquid diet 4 hours prior to exam (no oral prep)
	No prep	<input type="checkbox"/> CT Chest <input type="checkbox"/> Head <input type="checkbox"/> Sinuses <input type="checkbox"/> Bony Pelvis	No prep (no oral or IV)
<input type="checkbox"/> IVP	Laxative night before - No food/drink after midnight	<input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine	No prep (no oral or IV)
FLUORO *BA Swallow, UGI, and BA Enema are routinely done with air*	Prep Instructions:	<input type="checkbox"/> CT Neck Soft Tissues (IV only)	Clear liquid diet 4 hours prior to exam (no oral prep)
<input type="checkbox"/> BA Swallow w/air <input type="checkbox"/> BA Swallow w/o air <input type="checkbox"/> Request test tablet	No food or drink after midnight prior to exam	<input type="checkbox"/> CT Abd/Pelvis <input type="checkbox"/> Upper Abd only <input type="checkbox"/> Pelvis only *choose below*	Pick up oral prep at Clinic day prior to exam
<input type="checkbox"/> Upper GI Series w/air <input type="checkbox"/> Upper GI Series w/o air	No food or drink after midnight prior to exam	<input type="checkbox"/> Oral only <input type="checkbox"/> IV only <input type="checkbox"/> Oral & IV	Clear liquid diet 4 hours prior to exam
<input type="checkbox"/> Upper GI w/air, inc. SBS <input type="checkbox"/> Upper GI w/o air, inc. SBS	No food or drink after midnight prior to exam	<input type="checkbox"/> CT Stone Study - CT Abd/Pelvis without (no IV or oral)	Drink 16 oz prior to exam – Do not empty bladder
<input type="checkbox"/> Small Bowel Series <input type="checkbox"/> BA Enema w/air <input type="checkbox"/> BA Enema w/o air	Pick up prep kit at Clinic 2 days before exam	<input type="checkbox"/> CT Urogram (IV only)	Clear liquid diet 4 hours prior to exam (no oral prep)
<input type="checkbox"/> Other (i.e. arthrogram, injection, myelogram, etc.)	Call for prep if necessary	<input type="checkbox"/> CT Colonography	Pick up prep kit at Clinic at least 2 days prior to exam
ULTRASOUND	Prep Instructions:	MRI *no prep unless otherwise specified*	DEXA *no Calcium or multi-vitamin day before/day of exam*
<input type="checkbox"/> Upper Abdomen Complete <input type="checkbox"/> Liver (RUQ) <input type="checkbox"/> GB <input type="checkbox"/> Pancreas	No food or drink after midnight prior to exam	<input type="checkbox"/> Brain without <input type="checkbox"/> Brain wo/w contrast	<input type="checkbox"/> Bone Density Study <input type="checkbox"/> Body Composition
<input type="checkbox"/> Liver Elastography (Shear Wave - Fibroscan)	No food or drink after midnight prior to exam	<input type="checkbox"/> Cranial Nerves (Brain wo/w) – IAC's Protocol	MAMMOGRAM
<input type="checkbox"/> Renal Artery Doppler	No food or drink 12 hours prior to exam	<input type="checkbox"/> Orbits <input type="checkbox"/> Pituitary	<input type="checkbox"/> Screening MAMM TOMOSYNTHESIS W/CAD (Breast US or add'l views if mamm yields positive or equivocal results or otherwise warranted)
<input type="checkbox"/> Pelvic, Transvaginal if warranted <input type="checkbox"/> Pregnancy, TV if warranted	Drink 32 oz 45 min prior – Do not empty bladder	<input type="checkbox"/> TMJ <input type="checkbox"/> Chest / Mediastinum	<input type="checkbox"/> Diagnostic MAMM TOMOSYNTHESIS W/CAD (Breast US or add'l views if mamm yields positive or equivocal results or otherwise warranted)
if you want a limited abdomen or pelvis, please specify/provide details in the comments	Prep will vary, ask when scheduling	<input type="checkbox"/> Neck Soft Tissue <input type="checkbox"/> Brachial Plexus <input type="checkbox"/> Lumbar Plexus	
<input type="checkbox"/> Neck Soft Tissue <input type="checkbox"/> Breast Left / Right <input type="checkbox"/> Scrotum / Doppler	No prep	<input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine	
<input type="checkbox"/> Kidney <input type="checkbox"/> Spleen <input type="checkbox"/> Thyroid <input type="checkbox"/> Carotid <input type="checkbox"/> Arterial ABI's only	No prep	<input type="checkbox"/> Sacrum <input type="checkbox"/> Coccyx <input type="checkbox"/> SI Joint	
<input type="checkbox"/> Bilateral Extremities Upper / Lower <input type="checkbox"/> Venous <input type="checkbox"/> Complete Arterial	No prep	<input type="checkbox"/> Hip Left /Right <input type="checkbox"/> Bony Pelvis <input type="checkbox"/> Pelvis (organs)	COMMENTS:
<input type="checkbox"/> Unilateral Extremity Venous Upper / Lower <input type="checkbox"/> Left <input type="checkbox"/> Right	No prep	<input type="checkbox"/> MR Enterography wo/w contrast (NPO 6 hrs)	**if needed exam is not listed on this form, please specify the study below. Please also provide any additional details we should be aware of. **
<input type="checkbox"/> Extremity Non-vascular Upper / Lower <input type="checkbox"/> Left <input type="checkbox"/> Right	No prep	<input type="checkbox"/> Pancreas w/3D <input type="checkbox"/> MRCP w/3D (NPO 6 hrs)	
NUCLEAR MEDICINE	Prep Instructions:	<input type="checkbox"/> Liver <input type="checkbox"/> Kidneys <input type="checkbox"/> Adrenals	
<input type="checkbox"/> HIDA <input type="checkbox"/> HIDA with EF (Could take up to 1-3 hrs)	No food or drink after midnight prior to exam	<input type="checkbox"/> Shoulder Left / Right <input type="checkbox"/> Elbow Left / Right	
<input type="checkbox"/> Bone Scan Limited <input type="checkbox"/> Multiple <input type="checkbox"/> Whole Body <input type="checkbox"/> SPECT	Return to Clinic in 2 to 3 hours after dose for scan	<input type="checkbox"/> Wrist Left / Right <input type="checkbox"/> Hand Left / Right	
<input type="checkbox"/> I-123 Thyroid Scan	Return to Clinic in 4 to 6 hours after dose for scan	<input type="checkbox"/> Upper Arm Left / Right <input type="checkbox"/> Lower Arm Left / Right	
<input type="checkbox"/> I-123 Thyroid Uptake	Return to Clinic in 24 hours after dose for scan	<input type="checkbox"/> Upper Leg Left / Right <input type="checkbox"/> Lower Leg Left / Right	
<input type="checkbox"/> I-123 Thyroid Scan and Uptake	Return in 4-6 hrs & again 24 hrs after dose for scan	<input type="checkbox"/> Knee Left / Right <input type="checkbox"/> Ankle Left / Right <input type="checkbox"/> Foot Left / Right	
<input type="checkbox"/> Parathyroid Scan	Return to Clinic 3 to 4 hours after dose for scan	<input type="checkbox"/> Myositis Protocol Bilateral Lower Extremities Upper / Lower	
<input type="checkbox"/> Gastric Emptying (Could take up to 1-4 hrs) <input type="checkbox"/> Meckel's Scan	No food or drink after midnight prior to exam	<input type="checkbox"/> MRA: Brain / Neck (Carotid) / Abdomen (Renal) / Pelvis	
<input type="checkbox"/> Liver / Spleen Scan <input type="checkbox"/> MUGA Scan	No prep	<input type="checkbox"/> Arthrogram MRI: Shoulder / Elbow / Wrist / Hip / Knee <input type="checkbox"/> Left <input type="checkbox"/> Right	
<input type="checkbox"/> Renal Scan <input type="checkbox"/> Renal Scan with Lasix	Must be well hydrated		

The Location for The Radiology Clinic



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For Appointments
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