☐ **7806 lake Underhill Rd. Suite 101**
Orlando, FL 32822
Ph: 407-608-6800 Fax: 407-608-6747

☐ **911 E. Oak Street, Suite A**
Kissimmee, FL 34744
Ph: 407-847-3070 Fax: 407-847-2723

Date_________________

Patient's Name_________________________________

DOB:____________________

SS#___________________________

Referring Physician______________________________

Office Contact:_____________________________

Patient's Phone___________________________

Patients' Cell ____________________________

Patient Return Apt:___________________________

Prev. Films @______________________________

*All patients over 55 or any diabetic patients receiving IV Contrast for CT exams must have current lab work prior to their appointment (BUN & Creatinine levels) no older than 90 days. All Patients over 60 with high blood pressure and or diabetes receiving a MRI with IV contrast must have current lab work prior to their appointment (Creatinine levels).

Must select one for ALL CT and MRI exams:
____With/Without Contrast ____ No Contrast
____ With Contrast ____Contrast per Radiologist discretion

MRI/MRA High Field 1.5T (Lake Underhill)
MRI/MRA Open MRI (Kissimmee)

- ☐ **Cervical**
- ☐ **Thoracic**
- ☐ **Lumbar**
- ☐ **Brain**
- ☐ **IAC's (Internal Auditory Canal)**
- ☐ **Pituitary**
- ☐ **Abdomen**
- ☐ **Shoulder R / L**
- ☐ **Wrist R / L**
- ☐ **Knee R / L**
- ☐ **Elbow R / L**
- ☐ **MRA**
- ☐ **MRCP**

Other _________________

CT

- ☐ **Abdomen**
- ☐ **Pelvis**
- ☐ **Abdomen/Pelvis (Kidney Stone)**
- ☐ **Chest**
- ☐ **Brain**
- ☐ **Sinus**
- ☐ **Soft Tissue Neck**
- ☐ **Thoracic**
- ☐ **Brain**
- ☐ **Orbit**
- ☐ **Cervical**
- ☐ **Lumbar**
- ☐ **Extremity R / L**
- ☐ **Prostate**

Other: ________________

ULTRASOUND

- ☐ **Carotid Doppler E/F PAH**
- ☐ **Venous Doppler**
- ☐ **Arterial Doppler Lower/Upper**
- ☐ **ECHO**
- ☐ **Abdominal**
- ☐ **Pelvic**
- ☐ **Breast R / L**
- ☐ **Renal Doppler**
- ☐ **Testicular**
- ☐ **Thyroid**
- ☐ **RUQ/Liver**
- ☐ **Gallbladder**
- ☐ **Holter Monitor**

Other: _____________

X-RAY

- ☐ **Chest PA/LAT**
- ☐ **Chest**
- ☐ **ABD Series 1V(Stones)**
- ☐ **ABD Series 2V(Obstruction)**
- ☐ **ABD Series 3V(Free Air)**
- ☐ **Pelvis**
- ☐ **Lumbar**
- ☐ **Cervical**
- ☐ **Thoracic**
- ☐ **Extremity_________ R / L**

Other: ___________

Diagnosis:
____
____
____

Comments:____
____
____
____
____

I hereby authorize Professional Imaging Centers-VIP Scheduling to act on my behalf to obtain any and all authorizations needed for the above named patient. I hereby certify that the tests ordered are medically necessary for the diagnosis and treatment of this patient.

Physician's Name: ______________________________**Physician's Signature** ___________________________