



PROFESSIONAL IMAGING CENTERS

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 _____

Dr.'s 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)

- Brain
 - Cervical
 - Thoracic
 - Lumbar
 - IAC's (Internal Auditory Canal)
 - Pituitary
 - Abdomen
 - Shoulder R / L
 - Wrist R / L
 - Knee R / L
 - Elbow R / L
 - Foot R / L
 - Ankle R / L
 - MRA
 - MRCP
 - Paranasal/Sinuses
- Other: _____

CT/CTA – Multi-Slice

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

ULTRASOUND

- ECHO Doppler E/F PAH
 - ECHO Doppler Complete
 - Carotid Doppler
 - Venous Doppler Lower/Upper
 - Arterial Doppler Lower/Upper
 - Abdominal
 - Pelvic
 - Breast R / L
 - Renal Doppler
 - Testicular
 - Thyroid
 - 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
 - Foot R / L
 - Ankle R / L
 - Skull
- 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 _____