PROFESSIONAL IMAGING CENTERS

SUPERIOR DIAGNOSTIC IMAGING SERVICES

☐ **225 W. SR 434, Suite 104**
Longwood, FL 32750
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☐ **7806 Lake Underhill Rd. Suite 101**
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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

Patient's Name_____ Date of Birth_____ Today's Date_____ SSN:_____

Phone # (Home)_____Phone # (Work)_____Phone # (Cell)_____

Diagnosis / Symptoms:_____

❖ **Must select one for CT and MRI exams:** ☐ **With/Without Contrast** ☐ **With Contrast** ☐ **No Contrast**

MRI

☐ Contrast at Radiologist's Discretion

- ☐ Brain
- ☐ Chest - Non-Cardiac
- ☐ Cervical EXT/FLEX
- ☐ Thoracic
- ☐ Soft Tissue Neck
- ☐ Lumbar EXT/FLEX
- ☐ IAC's - W/O & W Only
- ☐ Pituitary - W/O & W Only
- ☐ Orbits
- ☐ Shoulder ☐ R ☐ L
- ☐ Hip ☐ R ☐ L
- ☐ Knee ☐ R ☐ L
- ☐ Foot ☐ R ☐ L
- ☐ Ankle ☐ R ☐ L
- ☐ Extremity
- ☐ Extremity _____
- ☐ Pelvic
- ☐ Abdomen
- ☐ MRCP (Abdomen & MRCP)
- ☐ Other:

MRA

With & Without Contrast

- ☐ Carotid
- ☐ Brain - Without Only
- ☐ Renal
- ☐ Lower Extremity Runoff
- ☐ Other:

MRV

- ☐ Brain
- ☐ Pelvic
- ☐ Extremity_____ ☐ R ☐ L
- ☐ Other:

CT

☐ Contrast at Radiologist's Discretion

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

CTA

☐ With ☐ W/O & W Contrast

- ☐ Chest
- ☐ Brain - W/O Contrast
- ☐ Neck/Carotid
- ☐ Aorta & Runoff
- ☐ Pelvis
- ☐ Abdomen
- ☐ Other:

PET/CT

- ☐ Skull Base-Mid - Routine
- ☐ Whole Body (Dx: Melanoma)
- ☐ Brain (Dx: Alzheimers)
- ☐ Full Body Bone Scan
- ☐ Other:

HOLTER

- ☐ 24 Hour Holter Monitor

DEXA

- ☐ Bone Density

ECHOCARDIOGRAM ULTRASOUND

- ☐ ECHO w/Doppler
  - ☐ Eval Diastolic Dysfunction
- ☐ PAH:

ULTRASOUND

- ☐ Carotid Doppler
- ☐ Venous Doppler:
  - ☐R ☐L ☐ Bil Ext._____
- ☐ Arterial Doppler: ☐ w/ABI ☐ wo/ABI
  - ☐R ☐L ☐ Bil Ext._____
- ☐ Abdominal Complete
- ☐ ABD Single Organ _____
- ☐ Breast ☐ R ☐ L
- ☐ Renal Doppler
- ☐ Renal Ultrasound
- ☐ Thyroid
- ☐ Aorta
- ☐ OB - 1st Trimester
- ☐ OB - After 1st Trimester
- ☐ Pelvic - Transabdominal
- ☐ Pelvic - Transvaginal
- ☐ Prostate
- ☐ Testicular
- ☐ Soft Tissue _____
- ☐ Extremity
- ☐ Other:

DIGITAL MAMMOGRAPHY

☐ R ☐ L ☐ Bil

- ☐ Digital Mammo Screening w/CAD
- ☐ Diagnostic Mammo w/CAD
- ☐ Digital Mammo Bilat DX
- ☐ Ultrasound if needed
- ☐ Other:

X-RAY

HEAD

- ☐ Sinuses
- ☐ Facial Bones
- ☐ Nasal Bones
- ☐ Mandible
- ☐ Bone Age Study
- ☐ Clavicle ☐ R ☐ L
- ☐ Elbow ☐ R ☐ L
- ☐ Forearm ☐ R ☐ L
- ☐ Hand ☐ R ☐ L
- ☐ Humerus ☐ R ☐ L
- ☐ Shoulder ☐ R ☐ L
- ☐ Wrist ☐ R ☐ L
- ☐ Chest
- ☐ Rib Series
- ☐ Sacrum
- ☐ ST Neck
- ☐ Ankle ☐ R ☐ L
- ☐ Femur ☐ R ☐ L
- ☐ Foot ☐ R ☐ L
- ☐ Hip ☐ R ☐ L
- ☐ Knee ☐ R ☐ L
- ☐ Tib/Fib ☐ R ☐ L
- ☐ Toes ☐ R ☐ L
- ☐ ABD Series 1V (Stones)
- ☐ ABD Series 2V (r/o Obstruction)
- ☐ ABD Series 3V (r/o Obstruction)
- ☐ Spine : _____
- ☐ Pelvis
- ☐ Sacrum/Coccyx
- ☐ Scoliosis Series
- ☐ Cervical EXT / FLEX
- ☐ Thorasic EXT / FLEX
- ☐ Lumbar EXT / FLEX
- ☐ Other X-Ray:
- ☐ Other X-Ray:

☐ **CREATININE DRAW** *(Available on site)* We require Creatinine Levels less than 90-days old on patietnts who are DIABETIC, over 60 or have RENAL INSUFFICIENCY before contrast injections in CT and MRI. **CREATININE LEVEL**_____ **DATE DRAWN**_____

Special Comments and Request :

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** _____