

South Plainfield Radiology, Corp.

Patient's Name _____

Appointment Date _____ Time _____

PROPER INSURANCE AUTHORIZATION MUST BE OBTAINED PRIOR TO YOUR VISIT

AUTH# _____

ICD-9 _____

Clinical History/Indications _____

Referring Physician's Signature _____

OPEN MRI

IAC Accredited

with & w/o w/o

- | | | |
|--|--------------------------|--------------------------|
| ☐ Brain MRI | ☐ | |
| ☐ Pituitary | ☐ | ☐ |
| ☐ IACs | ☐ | ☐ |
| ☐ Orbits | ☐ | ☐ |
| ☐ TMJs | ☐ | ☐ |
| ☐ Paranasal Sinuses | ☐ | ☐ |
| ☐ Neck | ☐ | ☐ |
| ☐ Chest | ☐ | ☐ |
| ☐ Abdomen | ☐ | ☐ |
| ☐ Peivis | ☐ | ☐ |
| ☐ C-Spine | ☐ | ☐ |
| ☐ T-Spine | ☐ | ☐ |
| ☐ L-Spine | ☐ | ☐ |
| ☐ Saccrum/Coccyx | ☐ | ☐ |

with & w/o w/o

- | | | | | |
|-----------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| ☐ Elbow | ☐ | ☐ | ☐ | ☐ |
| ☐ Wrist | ☐ | ☐ | ☐ | ☐ |
| ☐ Hand | ☐ | ☐ | ☐ | ☐ |
| ☐ Ankle | ☐ | ☐ | ☐ | ☐ |
| ☐ Foot | ☐ | ☐ | ☐ | ☐ |
| ☐ Shoulder | ☐ | ☐ | ☐ | ☐ |
| ☐ Knee | ☐ | ☐ | ☐ | ☐ |
| ☐ Hip | ☐ | ☐ | ☐ | ☐ |
| ☐ Other: | _____ | | | |

ULTRASOUND

- | |
|--|
| ☐ Abdomen |
| ☐ Renal/Urinary Bladder/Abdomen |
| ☐ Aorta/Abdominal/Renal |
| ☐ Pelvis/Transabdominal |
| ☐ Pelvis/Transvaginal |
| ☐ Pregnancy |
| ☐ OB Sono I Trimester |
| ☐ OB Sono II Trimester |
| ☐ OB Sono III Trimester |
| ☐ Bio Physical Profile |
| ☐ Breast |
| ☐ Thyroid |
| ☐ Prostate |
| ☐ Testicular |
| ☐ Renal |
| ☐ IVC |
| ☐ PVR |
| ☐ ABI |
| ☐ Segmental Pressure |
| ☐ Others: _____ |

* All Ultrasounds done with Color Doppler

MUSCULOSKELETAL ULTRASOUND

- | | |
|-------------------------------------|-------------------------------------|
| ☐ Shoulder | ☐ Knee |
| ☐ Elbow | ☐ Hip |
| ☐ Hand/Wrist | ☐ Foot/Ankle |

GENERAL RADIOLOGY XRAY

- | | | |
|---|----------------------------|----------------------------|
| ☐ Skull | | |
| ☐ Orbits | ☐ R | ☐ L |
| ☐ Facial Bones | | |
| ☐ Nasal Bones | | |
| ☐ Paranasal Sinuses | | |
| ☐ Nasopharynx/Soft Neck Tissue | | |
| ☐ Cervical Spine | | |
| ☐ Thoracic Spine | | |
| ☐ Lumbar Spine/Pelvis | | |
| ☐ Peivis | | |
| ☐ Sacrum/Coccyx | | |
| ☐ SI Joints | | |
| ☐ Shoulder | ☐ R | ☐ L |
| ☐ Scapula | ☐ R | ☐ L |
| ☐ Clavicle | ☐ R | ☐ L |
| ☐ Chest PA/LAT | | |
| ☐ Ribs | ☐ R | ☐ L |
| ☐ Sternum | | |
| ☐ Arm/Humerus | ☐ R | ☐ L |
| ☐ Elbow | ☐ R | ☐ L |
| ☐ Forearm | ☐ R | ☐ L |
| ☐ Wrist | ☐ R | ☐ L |
| ☐ Hand | ☐ R | ☐ L |
| ☐ Finger | ☐ R | ☐ L |
| ☐ Abdomen - KUB | | |
| ☐ Hip | ☐ R | ☐ L |
| ☐ Femur | ☐ R | ☐ L |
| ☐ Knee | ☐ R | ☐ L |
| ☐ Tibia/Fibula | ☐ R | ☐ L |
| ☐ Ankle | ☐ R | ☐ L |
| ☐ Heel/Calcaneous | ☐ R | ☐ L |
| ☐ Foot | ☐ R | ☐ L |
| ☐ Toe | ☐ R | ☐ L |
| ☐ Skeletal Survey | | |
| ☐ Scoliosis Series | | |
| ☐ Other | _____ | |

In preparation for your exam, wear comfortable clothing that does not contain metal fasteners and zippers. Do not wear jewelry, eye makeup or hair clips. If you have any questions or concerns about our examples call our office before your scheduled appointment. Please arrive 20 minutes early for your scheduled appointment and bring all Insurance cards and forms. Please call South Plainfield Radiology to see if your test requires pre-authorization. Do not stop regular oral medication. If you are diabetic using insulin, bring a light snack with you.

- ☐ **MRI:** Indicate if you have a pacemaker, aneurysm clip or metal fragments in your body. South Plainfield Radiology uses an open MRI system for Patient comfort and to eliminate claustrophobia.
- ☐ **ULTRASOUND**
- ☐ **Pregnancy Ultrasound:** from 1-6 months, drink 24 oz. of liquid; from 6-9 months, drink 16 oz. of liquid 1 hour before. DO NOT EMPTY BLADDER.
- ☐ **Pelvic Ultrasound:** One hour before appointment, drink at least 2-3 (8 ounce glasses) of water. DO NOT URINATE.
- ☐ **Abdominal Ultrasound:** Absolutely nothing to eat or drink 8 hours before exam.