



- DOWNTOWN** – 1331 Lady Street, Columbia, SC 29201
- IRMO** – 7182 Woodrow St. Suite 101, Irmo, SC 29063
- NORTHEAST** – 710 Rabon Road, Suite 100, Columbia, SC 29203
- WEST COLUMBIA** – 2997 Sunset Blvd. West Columbia, SC 29169

Phone: 803.256.7646 Fax 803.936.9202

Patient's name: _____ DOB: _____

Mobile #: _____ Alternate #: _____

Does patient have implanted device? Yes No Make: _____ Model: _____

Appointment date: _____ Arrival time: _____ am / pm Appointment Time: _____ am / pm

Do not fax STAT orders

- Call patient to schedule
- Obtain authorization
Fax order, front/back of insurance card and any clinical information
- Revised order

MRI	CT	ULTRASOUND - GENERAL	X-RAY
<p>CONTRAST</p> <input type="radio"/> Radiologist Discretion <input type="radio"/> Without <input type="radio"/> With & W/O	<p>CONTRAST</p> <input type="radio"/> Radiologist Discretion <input type="radio"/> With <input type="radio"/> Without	<input type="radio"/> Thyroid <input type="radio"/> Abdomen <input type="radio"/> Right Upper Quadrant (Liver, Gallbladder, Rt Kidney, Pancreas) <input type="radio"/> Left Upper Quadrant (Spleen, Lt Kidney) <input type="radio"/> Aorta <input type="checkbox"/> Medicare Screening <input type="radio"/> Pelvic Uterus/Ovaries (Check one below) <input type="checkbox"/> w/Transvaginal if indicated <input type="checkbox"/> Transvaginal only <input type="checkbox"/> Transabdominal only <input type="radio"/> OB LMP_____/ EDD _____ (Check one below) <input type="checkbox"/> Less than 14 weeks w/ Transvaginal if indicated <input type="checkbox"/> More than 14 weeks <input type="radio"/> OB Limited LMP_____/ EDD _____ <input type="radio"/> Renal <input type="radio"/> Scrotum	<p>* Please have patient call to schedule X-ray appointment</p> <input type="radio"/> Specify: _____
<input type="radio"/> Brain <input type="checkbox"/> IAC <input type="checkbox"/> Pituitary <input type="radio"/> Orbits <input type="radio"/> Soft Tissue Neck <input type="radio"/> Cervical Spine <input type="radio"/> Thoracic Spine <input type="radio"/> Lumbar Spine <input type="checkbox"/> Dynawell (Downtown only) <input type="radio"/> Breast <input type="radio"/> Shoulder Rt Lt <input type="radio"/> Elbow Rt Lt <input type="radio"/> Wrist Rt Lt <input type="radio"/> Hand/Fingers Rt Lt <input type="radio"/> Hip Rt Lt <input type="radio"/> Knee Rt Lt <input type="radio"/> Ankle/Hindfoot Rt Lt <input type="radio"/> Foot/Forefoot Rt Lt <input type="radio"/> Abdomen <input type="radio"/> MRCP <input type="radio"/> Pelvis <input type="radio"/> Prostate <input type="checkbox"/> Fusion Protocol <input type="radio"/> Enterography <input type="radio"/> MRA of: _____ <input type="radio"/> MR Arthrogram Rt Lt <input type="radio"/> Other: _____	<input type="radio"/> Head <input type="radio"/> Orbits <input type="radio"/> Paranasal Sinus <input type="checkbox"/> Stealth/Brain Lab <input type="checkbox"/> Fusion <input type="radio"/> Temporal Bones/ IAC <input type="radio"/> Facial Bones <input type="radio"/> Soft Tissue Neck <input type="radio"/> Cervical Spine <input type="radio"/> Thoracic Spine <input type="radio"/> Lumbar Spine <input type="radio"/> Extremity Rt Lt <input type="radio"/> Chest <input type="checkbox"/> High Resolution <input type="checkbox"/> Super Dimension <input type="radio"/> Cardiac Score <input type="radio"/> Abdomen & Pelvis <input type="checkbox"/> CT Urogram <input type="checkbox"/> Stone Protocol <input type="radio"/> Abdomen (only) <input type="radio"/> Pelvis (only) <input type="radio"/> CTA of: (all w & w/o) _____ <input type="radio"/> CT Arthrogram Rt Lt <input type="radio"/> Other: _____	<p style="text-align: center;">ULTRASOUND - VASCULAR</p> <input type="radio"/> Carotid Doppler <input type="radio"/> Upper Venous Doppler (arm) <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Bilat <input type="radio"/> Lower Venous Doppler (leg) <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Bilat <input type="radio"/> Upper Arterial Doppler (arm) <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Bilat <input type="radio"/> Lower Arterial Doppler (leg) <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Bilat <input type="checkbox"/> with ABI <input type="checkbox"/> without ABI <input type="radio"/> ABI Only	<p style="text-align: center;">WOMEN'S IMAGING</p> <input type="radio"/> Screening Mammogram <input type="radio"/> DEXA
			<p style="text-align: center;">SPINE PAIN MANAGEMENT</p> <input type="radio"/> Epidural Steroid Injection <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="radio"/> Specific Level ____ R / L <input type="checkbox"/> Selective Nerve Root Block <input type="checkbox"/> Sacroiliac Joint Steroid Injection
			<p style="text-align: center;">REPORT DELIVERY</p> <p>*Please call to schedule all STATs</p> <input type="radio"/> STAT Fax - report in 2 hours Fax _____ <input type="radio"/> Call Report Radiologist will call referring doctor Backline/Cell _____
			<p style="text-align: center;">Standard report in 24-48 hours</p> <p style="text-align: center;">COMPARISON STUDIES</p> <input type="radio"/> Location: _____
	<p style="background-color: #003366; color: white; padding: 2px;">ADVANCED IMAGING</p> <input type="radio"/> 3D Reconstruction		

Insurance (Fax front and back of patient's card and any clinical information to 803.936.9202) Auth # (if referring obtaining): _____

Clinical Indications/Signs/Symptoms (required): _____

ICD-10 Code(s): _____ Office phone: _____

Provider name (printed): _____ Provider signature: _____ Date: _____

PATIENT INSTRUCTIONS: PREPARING FOR YOUR EXAM

BRING THIS ORDER WITH YOU TO YOUR SCHEDULED EXAM

MRI (Magnetic Resonance Imaging)

Our office will contact you 24 hours before your appointment to confirm your appointment and provide prep instructions.

Do not wear eye makeup or mascara for ANY Brain & Neck studies. Do not wear any jewelry or hairpins. Wear comfortable clothing.

Let us know if you have:

- Metallic fragments in your eyes or previous injury to the eye involving a metal object
- Any type of glucose monitoring device
- Any type of implanted mechanical pump
- Any type of surgery within the past 8 weeks
- A history of cancer
- A pacemaker/ defibrillator/ stimulator
- An aneurysm clip
- Any metallic/ electronic implant

Let us know if you are:

- Allergic to CT or MRI contrast
- Claustrophobic
 - If you are claustrophobic or anxious, we encourage you to discuss mild sedation options with your referring provider prior to your exam
- Pregnant/Nursing
- In need of special assistance

CT (Computed Tomography)

Our office will contact you 24 hours before your appointment to confirm your appointment and provide prep instructions.

Oral prep

- You may be given Readi-Cat, a Barium Sulfate suspension, to drink for your CT Scan.
- This is not a laxative. Its purpose is to enhance your digestive tract so that the radiologist can better visualize your anatomy during your CT Scan.
- If eating prior to exam, please eat only a light meal or snack.
- If you have ever had any reaction to X-ray dye, please call us at 803.256.7646 **prior** to your exam.

Ultrasound

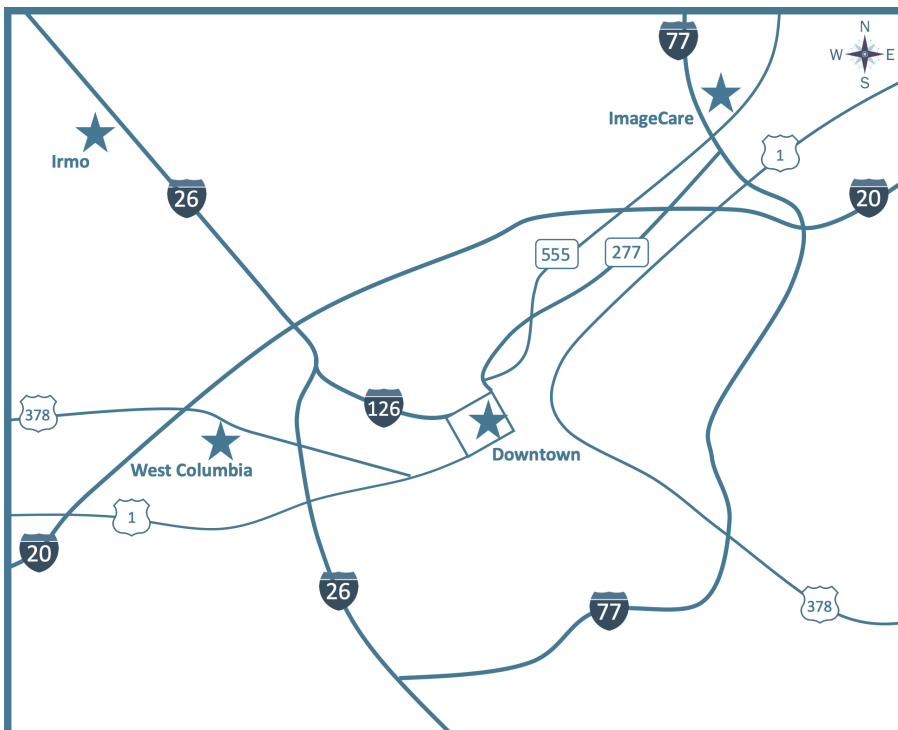
Our office will contact you 24 hours before your appointment to confirm your appointment and provide prep instructions.



Palmetto Imaging

Downtown | Irmo | West Columbia | ImageCare

www.SCDiag.com



Palmetto Imaging - Downtown

Tax ID# 57-1013875 OCM# SC002

**1331 Lady Street
Columbia, SC 29201**

Palmetto Imaging at ImageCare - Northeast

Tax ID# 57-1017301 OCM# SC656

**710 Rabon Road, Suite 100
Columbia, SC 29203**

Palmetto Imaging - Irmo

Tax ID# 57-1060462 OCM# SC671

**7182 Woodrow Street, Suite 101
Irmo, SC 29063**

Palmetto Imaging - West Columbia

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**2997 Sunset Blvd.
West Columbia, SC 29169**