Piedmont Imaging
www.SCDiag.com

684 N. Pine Street, Spartanburg, SC 29303
Tax ID: 58-2324016
Phone: 864.542.0033 • Fax: 864.542.0025

Patient's name: _____ DOB: _____

Mobile #: _____ Alternate #: _____ Insurance: _____

Appointment date: _____ Appointment time: _____ Authorization: _____

○ Call patient to schedule

Please call when scheduling all STAT exams

MRI

CONTRAST

○ Radiologist Discretion
○ W/O ○ W/ & W/O

○ Brain
○ C-spine
○ L-spine
○ T-spine
○ Shoulder R L
○ Ankle R L
○ Foot R L
○ Knee R L

○ MRA: _____

○ Other: _____

○ **Open MRI**

Screening

○ Health and Wellness Screening
○ Cardiac Score
○ CT Lung Screening

Implant

○ Pacemaker (no MRI)
○ Neurostimulator
○ Other:
Brand: _____
Serial #: _____

CT

CONTRAST

○ Radiologist Discretion
○ W/ ○ W/O

○ Brain
○ Orbit
○ Paranasal Sinus
○ Paranasal Sinus Stereotactic Protocol: _____
○ Temporal Bones
○ Facial Bones
○ Soft Tissue Neck
○ Chest
○ Abdomen
○ Pelvis
○ Abdomen & Pelvis
○ Abd/Pelvis Stone Protocol
○ C-spine
○ L-spine
○ T-spine
○ Other: _____
○ Dedicated Studies
☐ Adrenal
☐ Liver-Triple Phase
☐ Pancreas
☐ Renal-Triple Phase

Ultrasound

○ Abdomen
○ Limited Abdomen
○ Gallbladder
○ Renal (Kidneys & Bladder)
○ Aorta
○ Pelvic Complete
○ Transvaginal Pelvic
○ Pelvic with Transvaginal
○ Carotid Studies
○ Arterial Scan
☐ Unilat ☐ R ☐ L
☐ Bilat
☐ Upper Extremity (arms)
☐ Lower Extremity (legs)
○ Venous Scan
☐ Unilat ☐ R ☐ L
☐ Bilat
☐ Upper Extremity (arms)
☐ Lower Extremity (legs)
○ OB
○ Thyroid
○ Scrotum
○ Soft Tissue
☐ Specify: _____
○ Musculoskeletal
☐ Specify: _____
○ Other: _____

X-ray

Please specify:

○ Cervical
○ Thoracic
○ Lumbar
○ Hip R L
○ Knee R L
○ Other: _____

Comparison Studies

Date of service: _____

Location: _____

Type of study: _____

Report Delivery

○ STAT Fax
Fax#: _____

○ Call Report
Cell or backline #: _____

Standard Report in 24-48 hours.

Image Delivery

○ Send CD with patient

Insurance (Please fax front and back of patient's card and any clinical information to 864.542.0025)

Clinical indications/Signs/Symptoms: _____

ICD-10 Code(s): _____

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

Office phone: _____ **Fax:** _____ **Date:** _____

NOTE: CAREFULLY FOLLOW EXAM PREPARATION INSTRUCTIONS ON THE BACK SIDE OF THIS FORM

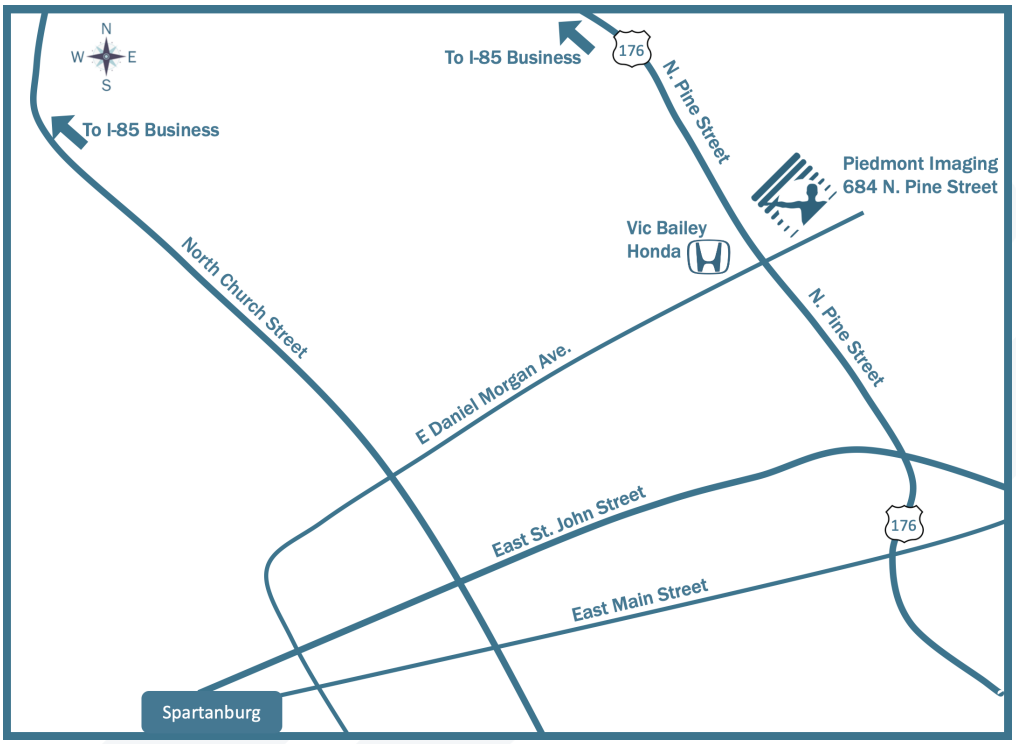
REV: 03.03.2020

PATIENT INSTRUCTIONS

BRING THIS ORDER WITH YOU TO YOUR SCHEDULED EXAM

VISIT US ONLINE AT WWW.SCDIAG.COM FOR DRIVING DIRECTIONS AND TO LEARN MORE ABOUT OUR IMAGING FACILITY AND SERVICES.

Our Location



ACR AMERICAN COLLEGE OF RADIOLOGY ACCREDITED FACILITY

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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 implanted mechanical pump
- Any type of surgery within the past 8 weeks
- A history of cancer
- A pacemaker
- An aneurysm clip
- Any metallic implant

Let us know if you are:

- Allergic to CT or MRI contrast
- Claustrophobic
- Pregnant/Nursing
- In need of special assistance

Ultrasound

Abdomen, Right Upper Quadrant, Renal, Aorta:

- Nothing to eat or drink after midnight or 8 hours prior to exam.

Renal or Transabdominal Pelvic

- Full bladder required. All must drink 32 oz. of water 1 hour prior to exam (if on a fluid restricted diet, please contact the office for other instructions).

CT (Computed Tomography)

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