



Patient's name: _____ DOB: _____

Mobile #: _____ Alternate #: _____ Insurance: _____

Appointment date: _____ Appointment time: _____ Authorization: _____

☐ Call patient to schedule

**Please call when
scheduling all STAT exams**

MRI	CT	ULTRASOUND	X-RAY
CONTRAST <input type="radio"/> Radiologist Discretion <input type="radio"/> W/ <input type="radio"/> W/O <input type="radio"/> W/ & W/O	CONTRAST <input type="radio"/> Radiologist Discretion <input type="radio"/> W/ <input type="radio"/> W/O	<input type="radio"/> Thyroid <input type="radio"/> Abdomen Complete <input type="radio"/> Right Upper Quadrant <i>(Liver, Gallbladder, Rt. Kidney, Pancreas)</i> <input type="radio"/> Left Upper Quadrant <i>(Spleen, Lt. Kidney)</i> <input type="radio"/> Aorta <input type="radio"/> Liver Only <input type="radio"/> Renal <i>(Kidneys & Bladder)</i> <input type="radio"/> Pelvis <i>(Female Only)</i> <input type="checkbox"/> Transabdominal <input type="checkbox"/> Transvaginal <i>(As Indicated)</i> <input type="radio"/> OB <i>(Transvaginal As Indicated)</i> <input type="radio"/> Scrotum <input type="radio"/> Soft Tissue Extremity <input type="checkbox"/> Location: _____ <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="radio"/> Soft Tissue Neck <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Anterior <input type="checkbox"/> Posterior <input type="radio"/> Soft Tissue Other Location: _____ <input type="radio"/> Hernia <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Epigastric <input type="checkbox"/> Umbilical <input type="checkbox"/> Abdominal <input type="checkbox"/> Inguinal <input type="radio"/> Other: _____	* Please have patient call to schedule X-ray appointment <input type="radio"/> Specify:
<input type="radio"/> Brain <input type="checkbox"/> IAC <input type="checkbox"/> Pituitary <input type="checkbox"/> Orbits <input type="checkbox"/> Seizure Protocol <input type="radio"/> TMJ <input type="radio"/> Soft Tissue Neck <input type="radio"/> Stroke Protocol <i>(Brain, MRA Head, MRA Neck)</i> <input type="radio"/> Cervical Spine <input type="radio"/> Lumbar Spine <input type="radio"/> Thoracic Spine <input type="radio"/> Abdomen <input type="radio"/> Pelvis <input type="radio"/> Prostate <input type="radio"/> MRCP <input type="radio"/> Shoulder Rt Lt Bilat <input type="radio"/> Elbow Rt Lt Bilat <input type="radio"/> Wrist Rt Lt Bilat <input type="radio"/> Hip Rt Lt Bilat <input type="radio"/> Knee Rt Lt Bilat <input type="radio"/> Ankle Rt Lt Bilat <input type="checkbox"/> Hindfoot <input type="radio"/> Foot Rt Lt Bilat <input type="checkbox"/> Midfoot <input type="checkbox"/> Forefoot <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"/> Lumbar Spine <input type="radio"/> Thoracic Spine <input type="radio"/> Chest <input type="radio"/> Cardiac Score <input type="radio"/> Abdomen & Pelvis <input type="checkbox"/> Stone Protocol <input type="radio"/> Abdomen (Only) <input type="radio"/> Pelvis (Only) <input type="radio"/> CTA (All W/ & W/WO) <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Head <input type="checkbox"/> Aorta <input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> LE Run-off <input type="radio"/> Dedicated Studies <i>(All W/ & W/WO)</i> <input type="checkbox"/> Adrenal <input type="checkbox"/> Pancreas <input type="checkbox"/> Liver <input type="checkbox"/> Renal <input type="radio"/> Other: _____	IMAGE DELIVERY <input type="radio"/> Send CD with patient <input type="radio"/> Courier to office	Advanced Imaging <input type="radio"/> 3D Reconstruction
			COMMENTS
			REPORT DELIVERY <input type="radio"/> STAT Fax Fax#: _____ <input type="radio"/> Call Report Cell or backline #: _____ Standard Report in 24-48 hours.
			COMPARISON STUDIES Date of service: _____ Location: _____ Type of study: _____
			IMPLANT <input type="radio"/> Pacemaker (no MRI) <input type="radio"/> Neurostimulator <input type="radio"/> Other: Brand: _____ Serial #: _____

Insurance (Please fax front and back of patient's card and any clinical information to 843.747.6565)

Clinical indications/Signs/Symptoms: _____

ICD-10 Code(s): _____

Provider name (printed): _____ Provider signature: _____

Office phone: _____ Fax: _____ Date: _____

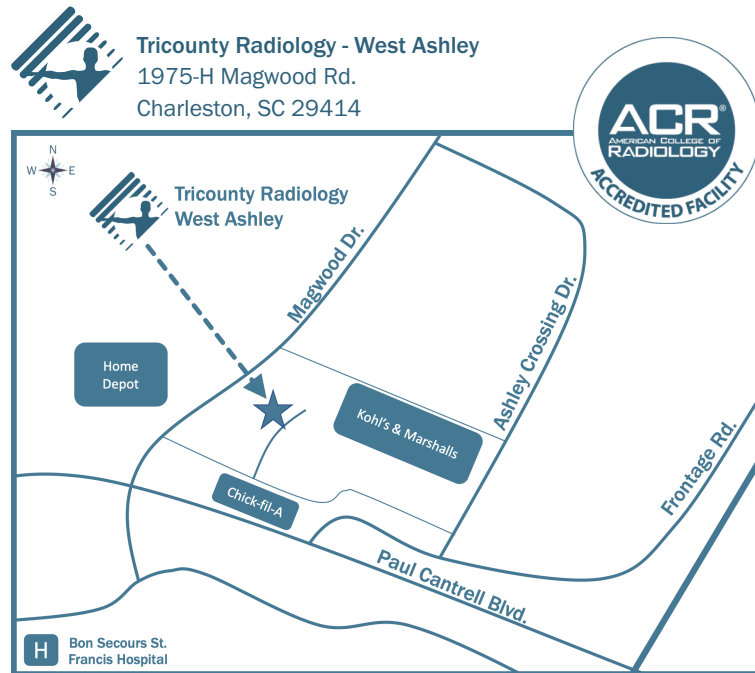
NOTE: CAREFULLY FOLLOW EXAM PREPARATION INSTRUCTIONS ON THE BACK SIDE OF THIS FORM

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 Locations



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/ defibrillator/ stimulator
- An aneurysm clip
- Any metallic/ electronic 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)

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



Tricounty Radiology
www.SCDiag.com