IMAGING PARTNERS
Diagnostic Medical Imaging

Email Order: scheduling@imagingpartners.com

Call to Schedule
714-997-4762

Fax Order
714-997-4763

Imaging Partners
1031 W. Chapman Ave., Suite 101
Orange, CA 92868

IMAGING PARTNERS OFFICE USE ONLY:

☐ **STAT**

☐ Call Report to Physician at: _____
Physician's Direct Phone Number

☐ **Verbal Order**

_____
Office Representative Name

_____
Initials

Please bring this completed order, your insurance card, and a photo ID with you to your appointment.

Today's date: _____ Appointment date: _____ Appointment time: _____

Patient Name: _____ DOB: ____/____/_____ ☐ **M** or ☐ **F** Patient Phone: _____
(last) (first) MM DD YYYY

Diagnosis/Current Symptoms/History: _____ ICD 10 Code: _____

Physician Signature: _____ Phone: _____ Fax: _____

Print Physician Name: _____

Additional Report to: _____ Phone: _____ Fax: _____

PRE-AUTHORIZATION MAY BE REQUIRED
For more information or assistance, please call (714) 997-4762

MRI
(with reconstruction as indicated)

- ☐ Brain
- ☐ Brain & IAC
- ☐ Brain & Pituitary
- ☐ Breast
- ☐ IAC Only
- ☐ Pituitary Only
- ☐ Orbits
- ☐ Neck Soft Tissue
- ☐ Spine:
  cervical _____
  thoracic _____
  lumbar _____
- ☐ Abdomen (indicate area of interest below)

_____

- ☐ MRCP
- ☐ Adrenals
- ☐ Pelvis
- ☐ Prostate
- ☐ Extremity: left____ right____
  indicate area of interest: _____
- ☐ **Other:**

_____

- ☐ **Without contrast**
- ☐ **With & without contrast**

MR Angiography (MRA)

- ☐ Brain
- ☐ Neck - Carotids
- ☐ Cardiac
  w/Flow____
- ☐ Chest
- ☐ Aorta
- ☐ Renals
- ☐ **Other:**

_____

- ☐ **Without contrast**
- ☐ **With & without contrast**

CT
(with reconstruction as indicated)

- ☐ Head / Brain
- ☐ Temporal Bones (IAC's)
- ☐ Sinus
- ☐ Maxillofacial – Facial Bones
- ☐ Neck Soft Tissue
- ☐ Shoulder: left____ right____
- ☐ Spine:
  cervical ____
  thoracic____
  lumbar _____
- ☐ Chest
- ☐ Abdomen
- ☐ Pelvis
- ☐ CT Urogram
- ☐ CT Stone Protocol
- ☐ Hip: left ____ right ____
- ☐ Extremity: left____ right____
  indicate area of interest: _____
- ☐ **Other:**

_____

- ☐ **With contrast**
- ☐ **Without contrast**
- ☐ **With & without contrast**

CT Angiography *(w & w/o contrast)*

- ☐ Head / Brain
- ☐ Neck - Carotids
- ☐ Chest
- ☐ Coronary
  w/FFR ____
- ☐ Cardiac
  Afib____ TAVR protocol____
  Watchmen Device ____
- ☐ Abdomen
- ☐ Pelvis
- ☐ **Other:**

_____

X-RAY

- ☐ Skull
- ☐ Orbits
- ☐ Sinuses:
  limited (waters) _____
  complete _____
- ☐ Shoulder: left____ right____
- ☐ Neck Soft Tissue
- ☐ Chest: PA____ PA/LAT____
- ☐ Ribs
  left____ right____
- ☐ Spine:
  cervical ____
  thoracic____
  lumbar____
- ☐ KUB
- ☐ Acute Abdominal Series
  2 view____ 3 view____
- ☐ Hip: left____ right____
- ☐ Bilateral Hips (w/pelvis)
- ☐ Pelvis
- ☐ Extremity: left____ right____
  indicate area of interest: _____
- ☐ **Other:**

_____

ULTRASOUND
(with Doppler as indicated)

- ☐ Carotid Doppler
- ☐ Venous Doppler
  upper extremity: left__ right__
  lower extremity: left__ right__
- ☐ Abdominal Aorta
- ☐ Abdomen
- ☐ Abdomen Limited:
  liver/galbadder____
  hernia _____
  appendix _____
- ☐ Renal Transplant
- ☐ Renal / Bladder
- ☐ Bladder
- ☐ Pelvic (w/ transvaginal as indicated)
- ☐ Pelvic Limited/Groin (Hernia)
- ☐ Hysterosonogram
- ☐ Scrotum
- ☐ Thyroid
- ☐ OB < 14 weeks
  (w/ transvaginal as indicated)
- ☐ OB > 14 weeks
  (w/ transvaginal as indicated)
- ☐ Fetal Survey (19 - 22 weeks)
  (w/ transvaginal as indicated)

EDD: _____

- ☐ Follow Up

Reason: _____

- ☐ **Other:** _____

PROCEDURES
(with reconstruction as indicated)

- ☐ Myelogram
  cervical____ thoracic____ lumbar____
- ☐ Arthrogram
  CT___ MR___ to follow
  body part: _____
- ☐ Pain Management
  body part: _____
- ☐ Aspiration
  body part: _____
- ☐ Hysterosalpingogram
- ☐ **Other:**

_____

GENERAL INSTRUCTIONS

Moran, Rowen & Dorsey, Inc.
EIN 95-2628283
NPI 1649263906

ULTRASOUND:

Gallbladder and/or Abdomen: Nothing to EAT or DRINK after midnight.
Pelvic, Obstetrics: 1.5 hrs prior to exam, empty bladder (urinate). Start drinking 24 ounces of water. Finish water in 30 minutes. Do not empty bladder until exam is completed.
Renal: Drink 16 ounces of water 30 minutes prior to exam. Do not empty bladder prior to exam.

CT SCAN:

CT Exams Requiring IV Contrast: Nothing to EAT or DRINK 4 hours prior to exam.
CT Exams Requiring Oral Contrast: Nothing to EAT or DRINK 4 hours prior to exam. Patients may pick up oral contrast at the facility prior to the appointment or arrive 1 hour prior to the exam. Please confirm your selection when scheduling your appointment.
*** Note:** Some CT exams require both oral and IV contrast. In addition, some CT exams require lab work prior to your visit, please inquire when scheduling.

MRI:

All MRI Exams: Notify office immediately if you have a **cardiac pacemaker, aneurysm clip, AICD (Cardiac Defibrillator), implanted device of any kind, or possible metal in your eye.**
MRI of the Abdomen: Nothing to Eat or Drink 4 hours prior to the exam.
***Note:** Some MRI exams require lab work prior to your visit, please inquire when scheduling.

Visit us at **www.imagingpartners.com**

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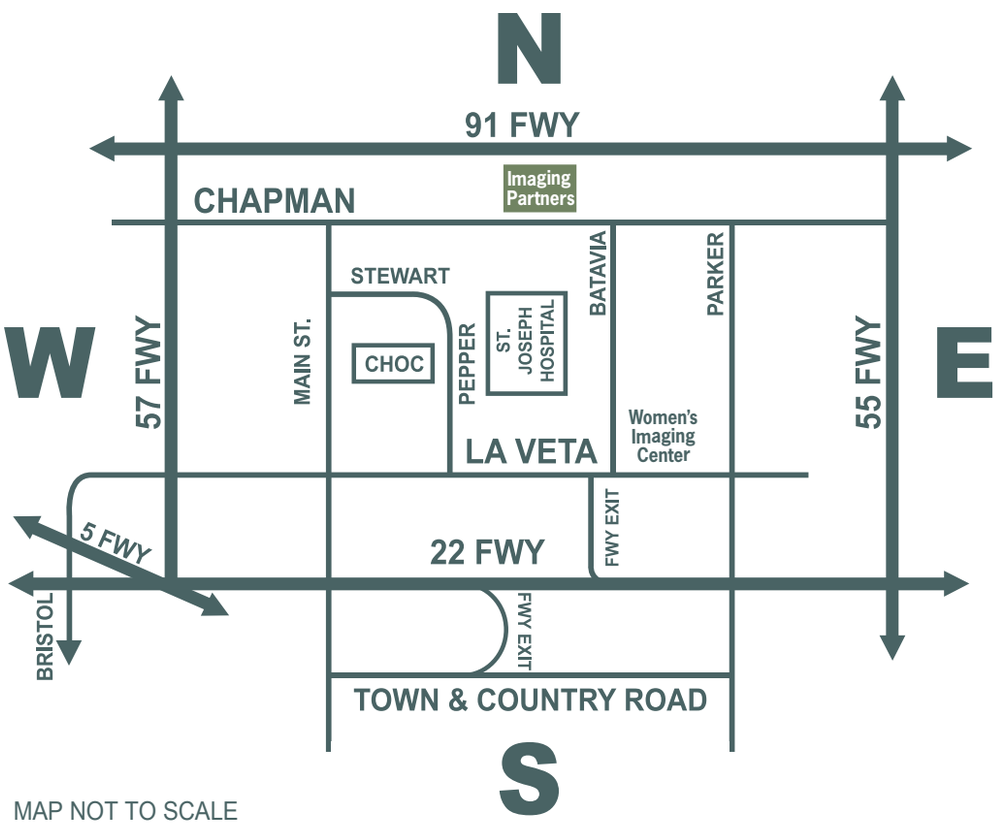

MAP NOT TO SCALE