RIVER RANCH RADIOLOGY™

DIRECT SCHEDULING: 512.454.9597 • 800.394.7226 • FAX FORM: 512.459.7449

Referring Physician:_____ Contact:_____

Pt. Name:_____ D.O.B._____

Pt. Home Phone #:_____ Alternate #:_____

Diagnosis / Symptoms:_____ Requested Radiologist:_____

Special Instructions:_____

_____

✱ **Exam Preparation** - Instructions attached. ❑ Diabetic / Kidney Problems ❑ Oral Sedation

Appt. Date:_____ Appt. Time:_____ ❑ am ❑ pm

Pre-Cert/Auth. #:_____

❑ Call patient to schedule ❑ Call/Fax with confirmation

❑ **STAT** call ph #_____ After hours #_____

❑ **STAT** fax # _____

❑ CD with pt. ❑ Deliver CD ❑ Fax Report _____

❑ Additional Report to Dr. _____

❑ **Medical Science Center** ❑ **Round Rock Center** ❑ **Post Oak Centre South** ❑ **Northwest Center**

❑ HI-FIELD MRI ❑ OPEN MRI

CT ORBIT SCREEN WILL BE PERFORMED AS NECESSARY

(W/=WITH CONTRAST - W/O=WITHOUT CONTRAST - PRN=CONTRAST PER RADIOLOGIST'S DISCRETION)

prn	w/	w/o	
❑	❑	❑	Brain
	❑		Perfusion
		❑	Diffusion
❑	❑	❑	Spectroscopy
❑	❑	❑	Brain & Spine MS protocol
❑	❑	❑	IACs
❑	❑	❑	Pituitary
❑	❑	❑	Pituitary w/ Brain
❑	❑	❑	Spine MS protocol
❑	❑	❑	Orbits
❑	❑	❑	Soft Tissue Neck
❑	❑	❑	TMJ
❑	❑	❑	Cervical
❑	❑	❑	Thoracic
❑	❑	❑	Lumbar (L1-S1)
❑	❑	❑	Sacrum
❑	❑	❑	SI Joints
❑	❑	❑	Chest
❑	❑	❑	Abdomen
❑	❑	❑	Pelvis
❑	❑	❑	MRCP (Gallbladder)
❑	❑	❑	Other: _____

prn	L	R	Extremities
❑	❑	❑	MR Arthrogram
❑	❑	❑	Shoulder
❑	❑	❑	Brachial Plexus
❑	❑	❑	Humerus
❑	❑	❑	Elbow
❑	❑	❑	Forearm
❑	❑	❑	Wrist
❑	❑	❑	Hand _____
❑	❑	❑	Hip
❑	❑	❑	Femur
❑	❑	❑	Knee
❑	❑	❑	Tib / Fib (Lower Leg)
❑	❑	❑	Ankle
❑	❑	❑	Foot _____
❑	❑	❑	Other:_____

❑ MRA

❑ Intracranial (Head / Circle of Willis)
❑ Extracranial (Neck / Carotids / Vertebrals)
❑ Thoracic
❑ Lower Extremity w/ Run off
❑ MRV _____
❑ Other: _____

❑ CT

ADDITIONAL VIEWS, REFORMATS, OR 3D RECON AT DISCRETION OF RADIOLOGIST

prn	w/	w/o	
❑	❑	❑	Brain
❑	❑	❑	Facial Bones
❑	❑	❑	Limited Sinuses
❑	❑	❑	Full Sinuses
❑	❑	❑	3-D IGS
❑	❑	❑	Orbits
❑	❑	❑	Temporal Bones / IACs
❑	❑	❑	Soft Tissue Neck
❑	❑	❑	Chest
	❑		Chest PE Protocol
❑	❑	❑	Abdomen w/ Pelvis if needed
❑	❑	❑	Pelvis
		❑	Kidney Stone Abd./ Pelvis
	❑		CT IVP Abd. / Pelvis

prn	w/	w/o	
❑	❑	❑	Cervical (levels: _____)
❑	❑	❑	Thoracic (levels: _____)
❑	❑	❑	Lumbar (levels: _____)
❑	❑	❑	Sacrum / Coccyx
❑	❑	❑	Upper Ext
❑	❑	❑	Lower Ext
		❑	Leg Length Discrepancy

❑ CTA

❑ Intracranial (Head / Circle of Willis)
❑ Extracranial (Neck / Carotids)
❑ Thoracic Aorta
❑ Abdominal Aorta
❑ Lower Extremity

❑ WELLNESS EXAMS

❑ Heart CT (Cardiac Scoring)
❑ Lung CT
❑ Full Body

❑ RADIOGRAPHY

NO APPOINTMENT NECESSARY FOR SINGLE OR TWO EXTREMITY EXAMS

HEAD
❑ Skull
❑ Facial Bones
❑ Nasal Bones
❑ Mandible
❑ Sinuses
❑ Waters View
❑ Orbits

CHEST
❑ PA & Lateral
❑ Ribs ❑ L ❑ R ❑ Bil.
❑ Sternum

ABDOMEN / PELVIS
❑ AP (KUB)
❑ AP & Upright Abdomen
❑ AP Pelvis

OTHER
❑ Bone Survey

SPINE
❑ Cervical
❑ 5 views ❑ 3 views
❑ flex & ext views
❑ Thoracic
❑ 2 views
❑ 3 views (swimmers incl.)
❑ Lumbar
❑ 5 views ❑ 3 views
❑ flex & ext views
❑ AP & Lateral Only C T L
❑ Lateral Only C T L
❑ Scoliosis Survey
❑ Sacroiliac Joints
❑ Sacrum
❑ Coccyx
❑ Other: _____

L	R	Upper Extremities
❑	❑	Clavical
❑	❑	Shoulder
❑	❑	A-C Joints
❑	❑	S-C Joints
❑	❑	Humerus
❑	❑	Elbow
❑	❑	Forearm
❑	❑	Wrist
❑	❑	Hand
❑	❑	Finger _____
❑	❑	Bone Age Study
	❑	Other: _____
		_____

L	R	Lower Extremities
❑	❑	Hip
❑	❑	Femur
❑	❑	Knee
❑	❑	Tib / Fib (Lower Leg)
❑	❑	Ankle
❑	❑	Foot
❑	❑	Toe _____
	❑	Other: _____

Other Exam Instructions
❑ Weight Bearing / Standing

❑ ARTHROGRAM

L	R	INCLUDES MRI
❑	❑	Shoulder
❑	❑	Elbow
❑	❑	Wrist
❑	❑	Hip
❑	❑	Knee
❑	❑	Ankle

❑ MYELOGRAM

INCLUDES POSTMYELO CT
❑ Cervical✱
❑ Thoracic✱
❑ Lumbar✱
❑ Entire Spine✱

❑ BONE DENSITOMETRY

❑ FLUOROSCOPY

❑ Upper GI✱
❑ SBFT✱
❑ Barium Swallow✱
❑ Barium Enema✱ (site specific)
❑ IVP✱
❑ Cystogram
❑ Lumbar Puncture

❑ PAIN MANAGEMENT

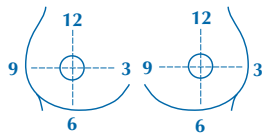
SITE SPECIFIC / RADIOLOGIST SPECIFIC
❑ Selective Nerve Root Block Injection ❑ ESI
❑ Facet Joint Injection ❑ Sacral Iliac Joint Injection

❑ ULTRASOUND

ANY STUDY MAY REQUIRE DOPPLER EVALUATION AT RADIOLOGIST'S DISCRETION

❑ Abdomen✱
❑ Gallbladder (RUQ)✱
❑ Liver✱
❑ Aorta✱
❑ Extremity Non-Vascular
❑ Renal
❑ Renal Transplant
❑ Testicular w/ Doppler
❑ Thyroid
❑ Other: _____
❑ Pelvic✱ (w/ transvaginal, if needed)
❑ Transvaginal✱
❑ Obstetrical✱ (w/ transvaginal, if needed)

❑ Breast✱
For Diagnostic Only.
Please note area of concern.
❑ Right ❑ Left



Special Instructions: _____
_____

❑ VASCULAR ULTRASOUND

ARTERIAL	VENOUS
❑ Up Ext ❑ LT ❑ RT	❑ Up Ext ❑ LT ❑ RT
❑ Low Ext ❑ LT ❑ RT	❑ Low Ext ❑ LT ❑ RT
❑ Carotid	❑ Abdominal / Pelvic Doppler✱
❑ Abdominal Aorta✱	❑ Hepatic
❑ Dialysis Fistula / Graft Loc.	❑ Portal
❑ Renal✱	❑ Renal
❑ Other: _____	❑ Mesenteric

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