



Tyler Open MRI & Diagnostic Center

A TOUCHSTONE CENTER



1904 E. Southeast Loop 323
Tyler, Texas 75701
Phone: 903.526.6736
Fax: 903.526.7911
www.tyleropenmri.com

Appt. Date: _____

Appt. Time: _____

Patient Name: _____ DOB: _____

Cell Phone: _____ Insurance ID#: _____

Home/Work Phone: _____ Authorization: _____

Referring Physicians Signature:

STAT CALL _____
Pager or cell phone # _____

Deliver Films or CD to Office
circle one

Send films or CD w/Patient
circle one

May modify exam at radiologists discretion if clinically indicated

Scan as Ordered

Diagnosis: _____

Print Referring Dr.: _____ Referring Office Contact: _____

Office Phone: _____ Office Fax: _____

HIGHFIELD MRI

- | | | | | | | |
|---|--|--|---|--------------------------------------|-----------------------------------|----------------------------|
| <input type="checkbox"/> Open | <input type="checkbox"/> High Field 1.5T | <input type="checkbox"/> Cervical Spine | <input type="checkbox"/> Thoracic Spine | <input type="checkbox"/> Elbow | <input type="checkbox"/> L | <input type="checkbox"/> R |
| <input type="checkbox"/> With/Without Contrast | <input type="checkbox"/> Without Contrast | <input type="checkbox"/> Lumbar Spine | <input type="checkbox"/> Sacrum | <input type="checkbox"/> Wrist | <input type="checkbox"/> L | <input type="checkbox"/> R |
| * Labs Needed For IV Contrast IF:
<input type="checkbox"/> Age 60 & Up <input type="checkbox"/> Diabetic <input type="checkbox"/> Renal DX
Creatinine: _____ | | <input type="checkbox"/> TMJ | | <input type="checkbox"/> Hand | <input type="checkbox"/> L | <input type="checkbox"/> R |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Draw Labs if Needed | <input type="checkbox"/> Abdomen | | <input type="checkbox"/> Knee | <input type="checkbox"/> L | <input type="checkbox"/> R |
| <input type="checkbox"/> Orbits | <input type="checkbox"/> Orbits & Brain | <input type="checkbox"/> Brachial Plexus | | <input type="checkbox"/> Ankle | <input type="checkbox"/> L | <input type="checkbox"/> R |
| <input type="checkbox"/> Pituitary | | <input type="checkbox"/> Abdomen Attn: _____ | | <input type="checkbox"/> Foot | <input type="checkbox"/> L | <input type="checkbox"/> R |
| <input type="checkbox"/> Internal Auditory Canals (IAC's) | | <input type="checkbox"/> MRCP | | <input type="checkbox"/> MRA Head | <input type="checkbox"/> MRA Neck | |
| <input type="checkbox"/> Soft Tissue Neck | | <input type="checkbox"/> Pelvis | | <input type="checkbox"/> MRA Renal | | |
| | | <input type="checkbox"/> Hip | <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Other _____ | | |
| | | <input type="checkbox"/> Shoulder | <input type="checkbox"/> L <input type="checkbox"/> R | | | |

CT

- | | | | | | |
|---|---|--|--------------------------------------|--|----------------------------|
| <input type="checkbox"/> With/Without Contrast | <input type="checkbox"/> Without Contrast | <input type="checkbox"/> Temporal Bones | <input type="checkbox"/> Extremity | <input type="checkbox"/> R | <input type="checkbox"/> L |
| * Labs Needed For IV Contrast IF:
<input type="checkbox"/> Age 60 & Up <input type="checkbox"/> Diabetic <input type="checkbox"/> Renal DX
Creatinine: _____ | | <input type="checkbox"/> IVP w/CT cuts | (specify) _____ | | |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Draw Labs if Needed | <input type="checkbox"/> Neck (Soft Tissue) | <input type="checkbox"/> Hip | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Pituitary | | <input type="checkbox"/> Chest | CT ANGIOGRAPHY 3D Reformat | | |
| <input type="checkbox"/> Orbits | | <input type="checkbox"/> Abdomen | <input type="checkbox"/> CTA Aorta | | |
| <input type="checkbox"/> Sinuses | <input type="checkbox"/> Coronal <input type="checkbox"/> Axial & Coronal | <input type="checkbox"/> Pelvis | <input type="checkbox"/> CTA Neck | | |
| <input type="checkbox"/> Mandible/Facial Bones | | <input type="checkbox"/> Abdomen / Pelvis | <input type="checkbox"/> CTA Renal | | |
| <input type="checkbox"/> Internal Auditory Canals | | <input type="checkbox"/> Kidney Stone Protocol Abd/Pel w-o | <input type="checkbox"/> CTA Chest | <input type="checkbox"/> (P.E. Protocol) | |
| | | <input type="checkbox"/> Cervical Spine | <input type="checkbox"/> Other _____ | | |
| | | <input type="checkbox"/> Thoracic Spine | | | |
| | | <input type="checkbox"/> Lumbar Spine | | | |

ULTRASOUND

- | | | |
|---|---|--|
| <input type="checkbox"/> OB Less Than 14 Weeks (w/TV if needed) | <input type="checkbox"/> Abdomen Complete (NPO) | <input type="checkbox"/> Carotid Doppler |
| <input type="checkbox"/> OB More Than 14 Weeks | <input type="checkbox"/> Abdomen Limited (NPO) | VENOUS DOPPLER (specify below) |
| <input type="checkbox"/> OB Bio Physical Profile | <input type="checkbox"/> Pelvis w/ Transvaginal (if needed) | <input type="checkbox"/> Lower Extremity <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Soft Tissue _____ | <input type="checkbox"/> Upper Extremity <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Testicular/Scrotal w/Doppler | <input type="checkbox"/> Abdominal Doppler | <input type="checkbox"/> Arterial Doppler w/ABI |
| <input type="checkbox"/> Renal | <input type="checkbox"/> Renal Doppler | |

X-RAY

- | | | |
|--|---|---|
| <input type="checkbox"/> Skull Complete | <input type="checkbox"/> KUB | <input type="checkbox"/> Toe (specify) _____ |
| <input type="checkbox"/> Facial Bones | <input type="checkbox"/> Abdomen Series | <input type="checkbox"/> Shoulder <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Sinuses | <input type="checkbox"/> Pelvis AP | <input type="checkbox"/> Humerus <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Chest PA & Lateral | <input type="checkbox"/> Hip <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Elbow <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> IVP | <input type="checkbox"/> Femur <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Forearm <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Ribs (specify) <input type="checkbox"/> Bilateral <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Knee <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Wrist <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Cervical Spine 2v, 4v, 6 view | <input type="checkbox"/> Tibia/Fibula <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Hand <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Thoracic Spine | <input type="checkbox"/> Ankle <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Finger (specify) _____ |
| <input type="checkbox"/> Lumbar Spine 2v, 4v, 6 View | <input type="checkbox"/> Foot <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Other _____ |

PLEASE FAX COPY OF PATIENT DEMOGRAPHICS & INSURANCE CARDS

