



Tyler Open MRI

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 # _____

May modify exam at radiologists discretion if clinically indicated

Scan as Ordered

Deliver Films or CD to Office
circle one

Diagnosis: _____

Send films or CD w/Patient
circle one

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"/> With/Without Contrast <input type="checkbox"/> Without Contrast	<input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Sacrum	<input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> MRA Head <input type="checkbox"/> MRA Neck <input type="checkbox"/> MRA Renal <input type="checkbox"/> Arthrogram <input type="checkbox"/> Other _____	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> R <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"/> Abdomen <input type="checkbox"/> Brachial Plexus <input type="checkbox"/> Abdomen Attn: _____ <input type="checkbox"/> MRCP <input type="checkbox"/> Pelvis <input type="checkbox"/> Hip <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Shoulder <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Extremity <input type="checkbox"/> R <input type="checkbox"/> L (specify) _____ <input type="checkbox"/> Hip <input type="checkbox"/> R <input type="checkbox"/> L CT ANGIOGRAPHY 3D Reformat <input type="checkbox"/> CTA Aorta <input type="checkbox"/> CTA Neck <input type="checkbox"/> CTA Renal <input type="checkbox"/> CTA Chest <input type="checkbox"/> (P.E. Protocol) <input type="checkbox"/> Arthrogram <input type="checkbox"/> Other _____	
	<input type="checkbox"/> Brain <input type="checkbox"/> Draw Labs if Needed <input type="checkbox"/> Orbits <input type="checkbox"/> Orbits & Brain <input type="checkbox"/> Pituitary <input type="checkbox"/> Internal Auditory Canals (IAC's) <input type="checkbox"/> Soft Tissue Neck	<input type="checkbox"/> Temporal Bones <input type="checkbox"/> IVP w/CT cuts <input type="checkbox"/> Neck (Soft Tissue) <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Abdomen / Pelvis <input type="checkbox"/> Kidney Stone Protocol Abd/Pel w-o <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine		
	<input type="checkbox"/> With/Without Contrast <input type="checkbox"/> Without Contrast * 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"/> OB Less Than 14 Weeks (w/TV if needed) <input type="checkbox"/> OB More Than 14 Weeks <input type="checkbox"/> OB Bio Physical Profile <input type="checkbox"/> Thyroid <input type="checkbox"/> Testicular/Scrotal w/Doppler <input type="checkbox"/> Renal	<input type="checkbox"/> Abdomen Complete (NPO) <input type="checkbox"/> Abdomen Limited (NPO) <input type="checkbox"/> Pelvis w/ Transvaginal (if needed) <input type="checkbox"/> Soft Tissue _____ <input type="checkbox"/> Abdominal Doppler <input type="checkbox"/> Renal Doppler	<input type="checkbox"/> Carotid Doppler VENOUS DOPPLER (specify below) <input type="checkbox"/> Lower Extremity <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Upper Extremity <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Arterial Doppler w/ABI
CT	<input type="checkbox"/> Brain <input type="checkbox"/> Draw Labs if Needed <input type="checkbox"/> Pituitary <input type="checkbox"/> Orbits <input type="checkbox"/> Sinuses <input type="checkbox"/> Coronal <input type="checkbox"/> Axial & Coronal <input type="checkbox"/> Mandible/Facial Bones <input type="checkbox"/> Internal Auditory Canals			
	<input type="checkbox"/> Skull Complete <input type="checkbox"/> Facial Bones <input type="checkbox"/> Sinuses <input type="checkbox"/> Chest PA & Lateral <input type="checkbox"/> IVP <input type="checkbox"/> Ribs (specify) <input type="checkbox"/> Bilateral <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Cervical Spine 2v, 4v, 6 view <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine 2v, 4v, 6 View	<input type="checkbox"/> KUB <input type="checkbox"/> Abdomen Series <input type="checkbox"/> Pelvis AP <input type="checkbox"/> Hip <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Femur <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Knee <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Tibia/Fibula <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Ankle <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Foot <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Toe (specify) _____ <input type="checkbox"/> Shoulder <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Humerus <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Elbow <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Forearm <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Wrist <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Hand <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Finger (specify) _____ <input type="checkbox"/> Other _____	
ULTRASOUND				
X-RAY				

PLEASE FAX COPY OF PATIENT DEMOGRAPHICS & INSURANCE CARDS



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If you have had previous diagnostic studies of the body part being evaluated, please bring those films and reports, or request they be sent to the Center. These studies or reports are very helpful to the Radiologist interpreting your exam.

MAGNETIC RESONANCE IMAGING (MRI)

Please let your MRI Technologist know if you have a pacemaker, surgical clips, a prosthesis, previous surgery, metal implants or any other metal objects in your body. Some implants (e.g. a pacemaker) may be affected by a MRI examination. Clinic personnel will determine whether or not you should proceed with the MR examination.

COMPUTED TOMOGRAPHY (CT)

Abdomen or Abdomen and Pelvis

You have the option of contacting our office to obtain your contrast (2% barium sulfate) two days prior to your exam. Eat a light dinner the evening before your exam and have nothing to eat or drink after midnight. You may take your regular medications with a small amount of water.

Oral Contrast Directions

On the day of your exam, drink one bottle (450ml) of your contrast two hours before your exam. Drink the second bottle (450ml) one hour before your exam.

If you are scheduled after 12:00 PM, you may eat a light nondairy breakfast (unsweetened juice or black coffee, dry toast, crackers) up to four hours before your exam.

Tell the CT Technologist:

- If you are pregnant or breast feeding
- If you have had a barium enema or UGI within the last two weeks
- If you have had brain, heart, ear, eye or other surgeries
- If you have had an IVP within 48 hours

Chest with IV Contrast

No food or liquids four hours before exam. Please check in 10-15 minutes prior to your exam.

ULTRASOUND

These are general guidelines. Please contact the center prior to your appointment for detailed instructions.

Abdominal Ultrasound:

Please do not eat or drink (NPO) 6-8 hours prior to the exam.

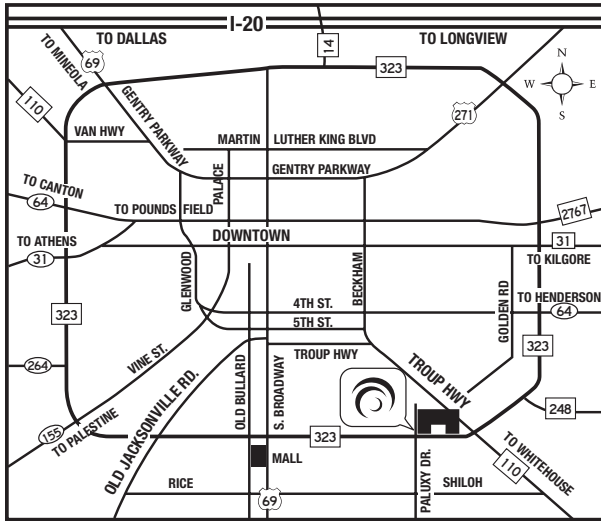
Pelvic/OB <30 weeks:

Please drink four 8-ounce glasses of water 1 hour prior to your appointment time. Your bladder must be full upon arrival.

Renal Ultrasound:

No prep.

- Most Insurances Accepted
- Discounted Cash Prices
- Evening and weekend appointments
- Reports to physicians within 24 hours
- Online Image / Report Viewer



From Athens

Start out going West on TX-31 / Chandler Hwy toward TX-323 Loop / S Southwest Loop 323.

Turn Right onto TX-323 Loop / S Southwest Loop 323.

Continue to follow TX-323 Loop S.

Turn Left at Paluxy Drive.

Turn Right at fourth entrance to shopping center.

From Henderson

Start out going West on TX-64.

Turn Left onto TX-323 Loop / S Southwest Loop 323.

Turn Right at Paluxy Drive.

Turn Right at fourth entrance to shopping center.

From Lindale

Start out going South on US Hwy 69 toward TX-323 Loop.

Turn Right onto TX-323 Loop / N Northwest Loop 323.

Continue to follow TX-323 Loop S.

Turn Left at Paluxy Drive.

Turn Right at fourth entrance to shopping center.

From Jacksonville

Take US-69 N.

Turn Right onto TX-323 Loop / E Southwest Loop 323.

Turn Left at Paluxy Drive.

Turn Right at fourth entrance to shopping center.

From Palestine

Start out going 155 North towards Frankston.

Continue to Loop 323 in Tyler

Take right on Loop 3232.

Turn Left at Paluxy Drive.

Turn Right at fourth entrance to shopping center.