

Patient Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Signs, Symptoms, Diagnosis: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

**MAGNETIC RESONANCE IMAGING / MRI**

**MRA / ANGIOGRAPHY**

with contrast     with & without contrast     without contrast

**HEAD**

- Brain
- IAC'S
- Orbits
- Pituitary
- Posterior Fossa
- Sinuses

**SPINE**

- Cervical Spine
- Thoracic Spine
- Lumbar Spine
- NECK
- CHEST
- ABDOMEN
- PELVIS

- KNEE
- SHOULDER
- HIP
- ANKLE

- FOOT
- WRIST
- HAND

- LEFT
- RIGHT
- BOTH
- OTHER JOINT: \_\_\_\_\_

- Abdomen
- Aorta
- Carotids
- Chest
- Circle of Willis
- Extremity
- Head
- Neck
- Pelvis
- Renal
- Spine
- Other: \_\_\_\_\_

**CAT SCAN**

with contrast     with & without contrast     without contrast

- Chest
- Chest (High Resolution)
- Abdomen
- Pelvis
- Neck (Soft Tissue)
- Other (Specify): \_\_\_\_\_

- Head
- Orbits
- Sinuses
- Temporal Bones
- Facial Bones
- Upper Extremity
- Lower Extremity
- Specify: \_\_\_\_\_

- Cervical Spine
- Lumbosacral Spine
- Thoracic Spine

QTC Bone Densitometry

Specify Level: \_\_\_\_\_

Requested by Dr.: \_\_\_\_\_ Appointment Date: \_\_\_\_\_

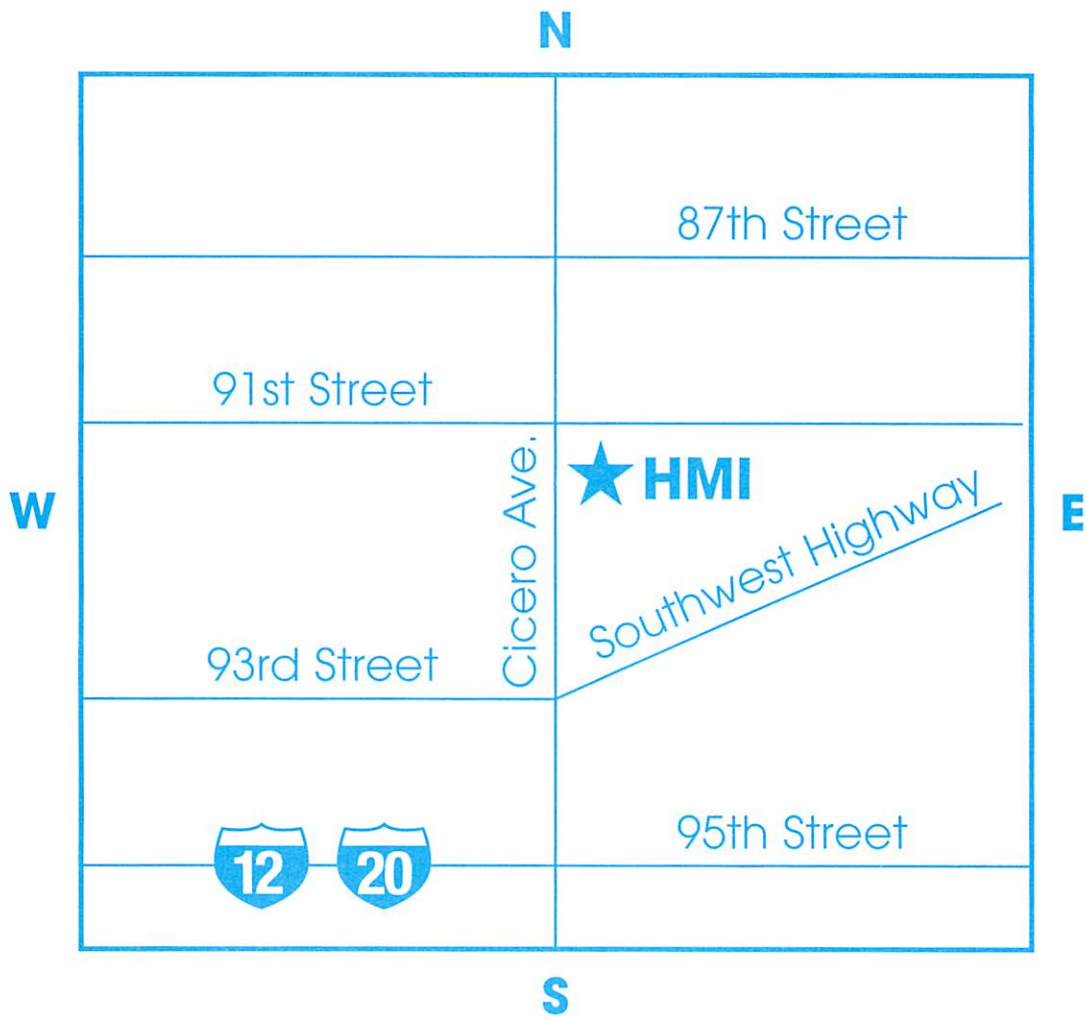
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Time: \_\_\_\_\_

Physicians Signature: \_\_\_\_\_

Films Requested                      Y      N

Give Films to Patient                Y      N

**Health**  
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