crosstimbers IMAGING

561 N Graham St
Stephenville, TX 76401
Phone 254-968-8600
Fax 254-918-5331

Name: _____ **SEX: M or F DOB:** _____

Patient Phone Number: _____ **Insurance:** _____

Diagnosis _____

ICD 10 Code _____

Ordering Physician _____ **Physicians Phone #** _____

☐ MRI (1.5T High Field)

☐ Without Contrast

- ☐ Brain
- ☐ Orbits
- ☐ Pituitary
- ☐ Internal Auditory Canals
- ☐ Soft Tissue Neck
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine
- ☐ Sacrum Spine
- ☐ Other _____

☐ With & Without Contrast

- ☐ MRA
- ☐ MRV
- ☐ Neck
- ☐ Chest/Pectoralis
- ☐ Abdomen
- ☐ MRCP/Liver
- ☐ Renal
- ☐ Pelvis
- ☐ Breast

☐ Radiologist Protocol

☐ L ☐ R ☐ Bilateral

- ☐ Shoulder
- ☐ Elbow
- ☐ Wrist
- ☐ Hand
- ☐ Hip
- ☐ Knee
- ☐ Ankle
- ☐ Foot
- ☐ Extremity _____

☐ CT

☐ Without Contrast ☐ With Contrast ☐ With & Without Contrast

Please Note with and without studies are at the discretion of Radiologist Protocol

☐ Labs Attached ☐ Draw Labs as Needed ☐ L ☐ R ☐ Bilateral ☐ 3D Recons

- ☐ Brain
- ☐ Orbits
- ☐ Sinuses
- ☐ Mandible/Facial Bones
- ☐ Temporal Bones
- ☐ Soft Tissue Neck
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine

- ☐ Chest
- ☐ Abdomen
- ☐ Pelvis
- ☐ CTA Head
- ☐ CTA Neck
- ☐ CTA Abdomen
- ☐ CTA Chest
- ☐ CTA Aorta
- ☐ CTA Runoff Bilateral

- ☐ Shoulder
- ☐ Elbow
- ☐ Wrist/Hand
- ☐ Hip
- ☐ Knee
- ☐ Ankle/Foot
- ☐ Extremity _____
- ☐ **CTA Coronary with FFR if needed**
- ☐ Calcium Scoring

☐ Ultrasound

- ☐ Abdominal Complete
- ☐ Abdominal Limited _____
- ☐ Aorta ☐ Diag ☐ Screening
- ☐ Renal complete
- ☐ Renal Artery Doppler
- ☐ Thyroid ☐ Thyroid FNA
- ☐ Soft Tissue _____
- ☐ Sacral Dimple/ Pedi Spine
- ☐ Other _____

- ☐ OB Bio Physical Profile
- ☐ OB < 14 weeks
- ☐ OB > 14 Weeks
- ☐ Trans Abdominal Pelvic
- ☐ Trans Vaginal Pelvic
- ☐ Bladder
- ☐ Testicular/Scrotal
- ☐ ABI

☐ L ☐ R ☐ Bilateral

- ☐ Carotid Doppler
- ☐ Arterial Doppler Upper EXT
- ☐ Arterial Doppler Lower EXT
- ☐ Mesenteric Artery Doppler
- ☐ Temporal Artery Doppler
- ☐ Venous Insufficiency Doppler
- ☐ Venous Doppler Upper EXT
- ☐ Venous Doppler Lower EXT
- ☐ Upper Extremity Vein Mapping

☐ Mammogram

- ☐ Screening Mammogram
- ☐ Contrast Enhanced Mammogram
- ☐ Bilat Diagnostic and Other exams as indicated
- ☐ Uni Lateral Daignostic ☐ L ☐ R

- ☐ Breast Ultrasound Screening
- ☐ Bilateral Diag Breast US
- ☐ Uni Diag Breast US ☐ L ☐ R

☐ L ☐ R ☐ Bilateral

- ☐ Stereo Breast Biopsy
- ☐ US Breast Biopsy
- ☐ US Breast Aspiration

☐ Additional Services

- ☐ X-ray ☐ L ☐ R ☐ Bilateral
  Exam Requested _____
  _____
- ☐ Bone Density
- ☐ Body Comp

- ☐ Therapeutic Joint Injection :_____
- ☐ Arthrogram: _____
- ☐ Image guidance per Radiologist Preference
- ☐ HSG

PLEASE FAX ORDER, PATIENT DEMOGRAPHICS, INSURANCE & CLINICALS TO 254-918-5513

Physician's Signature _____ Fax Number _____