PROMOTIONAL CONCEPTS INC (712) 623-9369

Ref. No: G 222508545

DIAGNOSTIC REQUEST FORM

North Jefferson Imaging
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Phone: (205) 418-1280 Fax (205) 418-1281
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Advancing the Art of Diagnostic Care

C. Michael Mead, M.D.

REQUEST FOR IMAGING STUDY

Appointment Date: ______________________ Exam Time: ______________________

Patient Name: ______________________ DOB: ______________________

Phone (H): ______________________ (C): ______________________ Sex: M ☐ F ☐

ICD 10 (required): ______________________ Obtain pre-cert? ☐ Yes ☐ No If yes please fax notes

Ins: (type/policy #): ______________________ Pre-cert #: ______________________

Referring Physician (Print): ______________________ Physician's Signature: ______________________

Referring Physician's Phone #: ______________________ Fax #: ______________________

MRI/MRA	CT	CTA	X-RAY
☐ **W/Contrast** ☐ **W/O Contrast**	☐ **W/Contrast** ☐ **W/O Contrast**	☐ Head	☐ Chest ☐ Sinus
☐ MRA ☐ Head ☐ Carotids ☐ ________	☐ Abdomen / Pelvis	☐ Neck	☐ Spine ☐ KUB
☐ Brain	☐ Head	☐ Chest	☐ C ☐ T ☐ L
☐ Spine ☐ C ☐ T ☐ L	☐ Soft Tissue Neck	☐ Runoff	☐ Extremity: ________
☐ Shoulder ☐ R ☐ L	☐ Sinus ☐ Medtronic	☐ Abdomen / Pelvis	________________
☐ Wrist ☐ R ☐ L	☐ Temporal Bone	☐ Abdomen	☐ R ☐ L
☐ Elbow ☐ R ☐ L	☐ Chest ☐ LDCT Screening	(renal arteries)	
☐ Hip ☐ R ☐ L	☐ Abdomen		
☐ Knee ☐ R ☐ L	☐ Pelvis		
☐ Ankle ☐ R ☐ L	☐ Extremity ☐ R ☐ L		
☐ Foot ☐ R ☐ L	☐ Body Part ________________		
☐ MRE Abdomen / Pelvis	☐ Spine ☐ C ☐ T ☐ L		
☐ Arthrogram of: ____________	☐ Hip Injection		
☐ Other: ________________	☐ Other ________________		

Ultrasound	
☐ Abdomen	☐ Pelvic
☐ GB	☐ Transvaginal
☐ Renal	☐ Thyroid
☐ Renal Artery Doppler	☐ Testicular
☐ Aorta	☐ OB
☐ Carotid	☐ Arterial Doppler
☐ Venous Doppler	☐ Elastography
☐ Upper Extremity	☐ Echocardiogram
☐ Lower Extremity	
☐ R ☐ L ☐ B	

Comprehensive Breast Imaging	DEXA
☐ Digital Mammography: ☐ R ☐ L ☐ B Screening______ Diagnostic______ ☐ with 3D breast tomosynthesis ☐ Breast Ultrasound: ☐ R ☐ L ☐ B ☐ Breast MRI: ☐ R ☐ L ☐ B	☐ Bone Density

MRI Contradictions: Pacemaker_______ Aneurysm Clip________ Implanted Devices_______ Metal in Eye______

☐ Call Patient to Schedule ☐ Call Report / #______________________ ☐ Send films w/ Courier ☐ Send films w/ patient ☐ Digital Image (CD)