

281.422.9600 Scheduling
281.422.9655 Fax



3711 Garth Road
Baytown, TX 77521

Last Name:		First Name:		Primary Phone:		Sex <input type="checkbox"/> M <input type="checkbox"/> F	
DOB:		S.S. #		Secondary Phone:			
Insurance Carrier:		Name of Insured:		S.S. # of Insured:		Patient Follow up Date	
ID #:		Group #:				CD Copy <input type="checkbox"/> Copies of Film <input type="checkbox"/>	
Clinical Finding/Diagnosis:				Referring Physician Name:			
Physician's Signature:				Phone:			
				Fax:			

MRI		
Brain w/o		
Brain w + w/o		
Orbits / IAC / Pituitary		
Cervical Spine		
Cervical Spine w + w/o		
Thoracic Spine		
Thoracic Spine w + w/o		
Lumbar Spine		
Lumbar Spine w + w/o		
Shoulder	R	L
Wrist	R	L
Knee	R	L
Foot	R	L
Ankle	R	L
OTHER		

MRA		
Abdomen		
Head w/o		
Neck w/o		
OTHER		

XRAY	
Specify procedure and # of views	

CAT SCAN		
Brain w/o		
Brain w + w/o		
Sinus		
Sinus w+ w/o		
Temporal Bones		
Soft Tissue Neck	w/	w/o
Chest		
Chest w + w/o		
Abdomen		
Abdomen w + w/o		
Pelvis		
Pelvis w + w/o		
Cervical Spine		
Cervical Spine w + w/o		
Thoracic Spine		
Thoracic Spine w + w/o		
Lumbar Spine		
Lumbar Spine w + w/o		
Other Procedures/Special Instructions		

CONTRAST STUDIES:

All Patients over the age of 50,
Hypertensive, Diabetic or with
Kidney disease **MUST** have
BUN and Creatinine within 30
days.

ULTRASOUND		
Pelvic Complete		
Abdomen Complete		
Breast Unilateral	R	L
Breast Bilateral		
Renal		
Scrotum		
Gallbladder		
Liver		
OB Complete		
Transvaginal		
Carotid Doppler		
Venous Doppler	R	L
	Upper	Lower
Arterial Doppler	R	L
	Upper	Lower
OTHER		

