TOWER IMAGING VALENCIA
Imaging by Specialists
Main: (661) 753-5400
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ACR AMERICAN COLLEGE OF RADIOLOGY ACCREDITED FACILITY

PLEASE BRING THIS FORM, YOUR INSURANCE CARD AND PHOTO ID WITH YOU

PATIENT INFORMATION — Tax ID #95-4362483

NAME_____ D.O.B._____

PATIENT PHONE NUMBER (H)_____ (C)_____

EXAM DATE _____ EXAM TIME _____

DIAGNOSIS/SYMPTOMS: (DO NOT USE R/O) _____

WEIGHT_____ HEIGHT_____

REFERRING DR. _____ DR. PHONE # _____ C.C. TO DR(S) _____

☐ STAT REPORT ☐ REPORT & CD ☐ FAX REPORT #: _____

EXAM(S) ORDERED

PLEASE COMPLETE AS FULLY AS POSSIBLE AND DIRECT PATIENT TO FOLLOW APPROPRIATE PREP ON REVERSE

CONTRAST ☐ WITH ☐ WITHOUT ☐ WITH & WITHOUT ☐ RADIOLOGIST DISCRETION

NAME OF EXAM	EXAM FOCUS
☐ **MRI 1.5** ☐ **MRI 3T** ☐ **MR ANGIOGRAPHY**	☐ BRAIN ☐ PITUITARY ☐ ORBITS ☐ IAC'S ☐ SHOULDER ☐ C-SPINE ☐ T-SPINE ☐ L-SPINE ☐ PELVIS (BONY) ☐ HIPS ☐ KNEE ☐ ABDOMEN ☐ NECK (SOFT TISSUE) ☐ SACRUM ☐ ANKLE ☐ FOOT ☐ FACE ☐ PELVIC (SOFT TISSUE) ☐ LT_____ RT_____BILAT_____ ☐ BREAST ☐ GUIDED BREAST BIOPSY ☐ ENTEROGRAPHY ☐ PACEMAKER ☐ CLAUSTROPHOBIC ☐ OTHER METALS IN THE BODY ☐ OTHER (SPECIFY) _____
☐ **CT**	☐ BRAIN ☐ TEMP. BONES/IAC'S ☐ FACIAL BONES ☐ SINUS ☐ ORBITS ☐ CORONARY CALCIUM SCORE ☐ NECK ☐ C-SPINE ☐ T-SPINE ☐ L-SPINE ☐ LUNG SCREEN ☐ CHEST ☐ ABDOMEN ☐ ABDOMEN/PELVIS ☐ PELVIS ☐ UROGRAM ☐ OTHER (SPECIFY) _____
☐ **PET/CT** **FILL IN ALL SECTIONS 1, 2 & 3**	**1** ☐ PET BODY (BASE OF SKULL TO THIGH) ☐ MELANOMA PROTOCOL (WHOLE BODY) — ☐ PET BRAIN ONLY for brain only, choose ☐ FDG ☐ AMYLOID **2** FOR BODY, CHOOSE: ☐ FDG ☐ DOTATATE-Neuroendocrine ☐ PSMA-Prostate ☐ Axumin-Prostate ☐ Other ____ **3** CT FOR PET/CT BODY: MUST CHECK ONE ☐ CT FOR LOCALIZATION ONLY (NON CONTRAST) ☐ DIAGNOSTIC CT: ☐ NECK ☐ CHEST ☐ ABDOMEN ☐ PELVIS (IV CONTRAST) RECOMMENDED IF NOT PREVIOUSLY PERFORMED — IODINE ALLERGY: ☐ YES ☐ NO
☐ **CT ANGIOGRAPHY**	☐ HEAD ☐ CAROTID ☐ PULMONARY ☐ RENAL ☐ RUNOFF ☐ ABDOMINAL AORTOGRAM ☐ THORACIC AORTOGRAM ☐ OTHER (SPECIFY) _____
☐ **ULTRASOUND**	☐ CAROTID ☐ AORTA ☐ RENAL ☐ GALLBLADDER RUQ ☐ COMPLETE ABD. ☐ LIMITED ABD. ☐ PELVIS ☐ LIMITED OB ☐ SCROTUM ☐ THYROID ☐ L.E. VENOUS LT_____ RT_____BILAT_____ ☐ OTHER (SPECIFY) _____
☐ **X-RAY**	(SPECIFY) _____
☐ **BONE DENSITY SCREENING**	☐ DEXA

PREVIOUS IMAGING: ☐ Yes ☐ No What type? ☐ X-Ray ☐ CT ☐ Ultrasound ☐ MRI ☐ PET Results: ☐ Abnormal ☐ Normal

IF PREVIOUS IMAGING IS NOT AT TOWER IMAGING VALENCIA, PLEASE FILL OUT A SIGNED RELEASE WHICH WE CAN PROVIDE IN ORDER TO OBTAIN YOUR RECORDS

ADDITIONAL INFORMATION _____

PHYSICIAN TO PHYSICIAN CONTACT NUMBER _____

PHYSICIAN SIGNATURE _____ **DATE**_____

NOTE: CAREFULLY FOLLOW EXAM PREPARATION INSTRUCTIONS ON THE BACK OF THIS FORM