PLEASE FAX ORDERS TO (719) 867-7900
(719) 785-9000 option 1 for Scheduling *Attach additional notes as required and necessary*
Locations / Map on reverse side

PENRAD IMAGING

Date: _____ Patient Name: _____

DOB: _____ Patient # to schedule: _____

Insurance: _____ Authorization: _____

(719) 785-9000
(877) 6-PENRAD
(877) 673-6723
PENRAD.org

Symptoms, background information, or clinical history.

Please include **What, When and Where** the injury / illness occurred:

_____

_____

☐ **STAT**

☐ **CALL REPORT**

Contact _____

MRI / MRA ☐Contrast if indicated

☐MR Brain ☐IAC's ☐MR Cervical Spine
☐Orbits (Brain NOT included) ☐MR Lumbar Spine
☐ MRI Face ☐MR Thoracic
☐MRI Abdomen ☐MRCP
☐MRA Head w/o ☐MRA Neck w/wo
☐MRA Chest w/wo ☐MRA Abdomen w/wo
☐MRV Head w/wo ☐MRV IVC w/wo
☐MRI Joint: ☐L ☐ R Specify:

CT/CTA ☐Contrast if indicated

☐CT Head / Brain ☐CT IAC's
☐CT Sinus ☐Medtronic ☐CT Soft Tissue Neck
☐CT Chest ☐CT IVP
☐CT Abdomen ☐CT Abdomen & Pelvis
☐CT Pelvis ☐CT Enterography
☐CTA Head/COW ☐CTA Neck
☐CT Facial Bones ☐CTA Chest (r/o PE)
☐CTA Abdomen ☐CTA Abdomen/Pelvis
SPINE: ☐Cervical ☐Thoracic ☐Lumbar
☐CTA Abdomen/Pelvis with run-off
☐Joint: ☐L ☐ R
Specify_____
☐ Coronary Artery Calcium Scoring/HeartScreen
☐ Lung Cancer Screening

PET/CT

☐ PET with CT Skull Base to Mid-Thigh
☐with CT Neck w/contrast *if indicated*
☐ PET with CT Whole Body
☐with CT Neck w/contrast *if indicated*

Mammography

☐Screening
☐Diagnostic, bilateral
☐with breast ultrasound *if indicated*
☐Diagnostic, unilateral
☐L ☐ R ☐with breast ultrasound *if indicated*
☐Stereotactic Biopsy
☐L ☐ R ☐Bilateral ☐Multi-site

Nuclear Medicine

☐Bone Scan with 3 Phase ☐Bone Scan / Limited
☐Bone Scan / Whole Body ☐Bone Scan with SPECT
☐HIDA Scan ☐Gastric Emptying Study
☐Thyroid Uptake & Scan ☐Parathyroid Scan

Fluoroscopy

☐VCUG ☐IVP
☐HSG (Hysterosalpingogram)
☐Arthrogram (Specify): _____

Ultrasound - ☐Doppler If Indicated

☐Upper Abdomen (Doppler if Indicated)
☐Aorta (Doppler if Indicated) ☐ Soft Tissue Neck
☐Pelvic (Doppler if Indicated) ☐ Thyroid
☐Scrotum (Doppler if Indicated) ☐ Renal (includes Bladder)
☐Carotid (includes vertebral)
☐OB 1st Trimester Only (Doppler if Indicated)
☐Limited Abdomen: Specify_____
☐Arterial Extremity
☐L ☐ R ☐Bilateral ☐Arm ☐Leg
☐Venous Extremity
☐L ☐ R ☐Bilateral ☐Arm ☐Leg
☐Breast
☐L ☐ R ☐Bilateral

Diagnostic X-Ray:

Walk-ins ONLY - No Scheduled Appointments
X-Rays are only performed at the AMC, BRO, SGP, & TRI locations.
See back for more location information.

☐Specify Area(s):

DEXA

☐Bone Density ☐Forearm

Unlisted Exam(s):

_____

_____

Referring Provider: _____

Provider Signature: _____

Location: _____

Office Phone: _____ Fax: _____

PENRAD CONFIRMATION

Appt: Date & Time:_____

Location: _____