



- Send with patient
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To: _____

**Magnetic Imaging Affiliates
MRI Services**
5730 Telegraph Avenue
Oakland, CA 94609
PH: (510) 204-2744 FX: (510) 658-1277
Tax ID# 94-2953833

**Alta CT (at Herrick Hospital)
CT Services**
2001 Dwight Way
Berkeley, CA 94704
PH: (510) 204-3439 FX: (510) 204-5622
Tax ID# 94-3083464

Date: _____ **STAT (if an exam is needed on an emergency basis)**

Patient Name: _____ Patient's Phone: (H or C) _____ W _____

DOB: ____/____/____ Insurance: _____ Identification #: _____

Authorization Number: _____ CC Report to: _____

Referring Physician: _____ *Referring Physician's Signature:* _____

Referring Physician Phone: _____ Referring Physician Fax: _____

Diagnosis & Symptoms: _____

For any exam with IV Contrast, we require BUN/Creatinine levels on all patients age 60 or older, or with kidney disease, or are diabetic.


LABS CANNOT BE OLDER THAN 90 DAYS.

BUN: _____ **Creatinine:** _____ **Draw Date:** _____

Important: Please check all appropriate boxes if the patient has any of the following: history of iodine allergy contrast material reaction diabetes multiple myeloma sickle cell disease kidney disease Barium Enema or Upper GI within the past week Female patients of child-bearing age should inform us if they are, or might be, pregnant. If patient is diabetic, please list medication patient is taking: _____

WITHOUT CONTRAST **WITH CONTRAST (only available for CT exams)** **WITH AND WITHOUT CONTRAST**

MAGNETIC RESONANCE IMAGING (MRI/MRA)

MRI - HEAD	MRI - BODY	MRI - SPINE	MRI - EXTREMITY	MRI - BREAST	MRA/MRV:
<input type="checkbox"/> Brain Routine <input type="checkbox"/> Brain Perfusion <input type="checkbox"/> Brain Attention to: _____ <input type="checkbox"/> IACs <input type="checkbox"/> Orbits <input type="checkbox"/> Pituitary/Sella <input type="checkbox"/> Sinus <input type="checkbox"/> TMJ <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Neck (Soft Tissue) <input type="checkbox"/> Chest/Mediastinum <input type="checkbox"/> Heart <input type="checkbox"/> Brachial Plexus <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Abdomen/Liver/Kidneys <input type="checkbox"/> Pelvis <input type="checkbox"/> MRCP <input type="checkbox"/> Prostate <input type="checkbox"/> Rectum <input type="checkbox"/> Other _____	<input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Sacrum/Coccyx	Please Select: <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Foot <input type="checkbox"/> Ankle Arthrogram Injection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other _____	<input type="checkbox"/> MR Breast (Tumor) <input type="checkbox"/> MR Breast (Implants) <input type="checkbox"/> Breast Biopsy Procedure <input type="checkbox"/> MR Breast Pre Op Localization 	<input type="checkbox"/> Head Only (Circle of Willis) <input type="checkbox"/> Neck Only (Carotids/Vertebrae) <input type="checkbox"/> Head and Neck Only <input type="checkbox"/> MRV (Brain Only) <input type="checkbox"/> Aortic Arch <input type="checkbox"/> Aorta <input type="checkbox"/> Renal Arteries <input type="checkbox"/> Mesenteric Arteries <input type="checkbox"/> Aortoiliac Run Off

COMPUTED TOMOGRAPHY (CT)

CT - HEAD	CT - EXTREMITY	CT - SPINE	CT - ANGIOGRAM	CT - BODY
<input type="checkbox"/> Brain <input type="checkbox"/> Temporal Bones/IACs <input type="checkbox"/> Maxillofacial Bones <input type="checkbox"/> Orbits <input type="checkbox"/> Sinuses <input type="checkbox"/> Other _____	Please Select: <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Other <input type="checkbox"/> Scanogram (for leg length)	Levels: From _____ To _____ <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbosacral Spine	<input type="checkbox"/> Brain (Circle of Willis) <input type="checkbox"/> Neck (Carotids) <input type="checkbox"/> Pulmonary Embolism (Chest) <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Abdomen/Pelvis <input type="checkbox"/> Other _____	<input type="checkbox"/> Neck (Soft Tissue) <input type="checkbox"/> Chest <input type="checkbox"/> Interstitial Lung Protocol/HRCT <input type="checkbox"/> Pelvis <input type="checkbox"/> Abdomen <input type="checkbox"/> Kidney Stone <input type="checkbox"/> Abdomen/Pelvis <input type="checkbox"/> Urogram <input type="checkbox"/> Chest/Abdomen/Pelvis <input type="checkbox"/> Other _____

Comments: _____