American Health Imaging of Augusta
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APPOINTMENT DATE
_____/_____/_____
_____ AM / PM

Patient Name: _____ DOB: _____ Sex assigned at birth: M F

Patient Phone #: _____ ☐ Call patient to schedule appointment

Insurance Name/ ID #: _____ Auth #: _____

Diagnosis: _____

Contact Name: _____ Contact Phone #: _____

☐ CD ☐ Report Only
☐ STAT ☐ CALL REPORT TO: _____

Creatinine: _____ GFR: ____ Date Drawn: _____

MRI

☐ Without Contrast ☐ With Contrast ☐ With & Without

☐ Brain
- ☐ Brain for ARIA
- ☐ Cranial Nerve
- ☐ DTI
- ☐ IAC's
- _____
- ☐ Pituitary

☐ Orbits
☐ Brachial Plexus
☐ Chest
☐ C-Spine
☐ L-Spine
☐ T-Spine/Dorsal
☐ Abdomen
☐ MRCP

☐ Pelvis
- ☐ Boney
- ☐ Soft tissue

☐ Enterography
☐ Sacrum
☐ Soft Tissue (Neck)
☐ TMJ
☐ Fat Quantification

☐ Shoulder L R
☐ Scapula L R
☐ Elbow L R
☐ Wrist L R

☐ Hand L R
☐ Hip L R
☐ Knee L R
☐ Ankle L R

☐ Foot L R
☐ Other _____

CT

☐ Without Contrast ☐ IV only (no oral) ☐ Oral & IV

☐ Abdomen
☐ Abdomen/Pelvis
☐ Renal (wo/w IV)
☐ Enterography w/IV
☐ Liver (wo/w IV)
☐ Renal (wo/w IV)
☐ Pelvis

☐ Stone (NO ORAL)
☐ Brain
☐ Orbits
☐ Chest
- ☐ PE Protocol (CTA)

☐ IAC's/Temporal
☐ Calcium Scoring

☐ Sinus
☐ Sinus Stealth
☐ Soft Tissue Neck

☐ C-Spine
☐ T-Spine
☐ L-Spine

☐ Shoulder L R
☐ Elbow L R
☐ Wrist L R

☐ Hand L R
☐ Hip L R
☐ Knee L R

☐ Ankle L R
☐ Foot L R
☐ Other _____

ULTRASOUND

☐ With Doppler

☐ Aorta
☐ Carotid Bilateral
☐ Extremity Non-Vascular
☐ Retroperitoneal Renal
☐ Soft Tissue Neck
☐ Thyroid

☐ Lower Extremity Venous, Bilateral
☐ Lower Extremity Venous, Unilateral L R
☐ Upper Extremity Venous, Bilateral
☐ Upper Extremity Venous, Unilateral L R
☐ Scrotum

☐ Abdomen, Limited, Quadrant
☐ Abdomen, Complete
☐ TA & TV Pelvic
☐ Transvaginal Pelvic
☐ Pelvic, Non-OB limited
☐ Pelvic, Non-OB Complete (Transdominal)
☐ Renal/Bladder
☐ Renal w/ Doppler

ANGIOGRAPHY

☐ MR Angiography ☐ CT Angiography
☐ Without Contrast ☐ With Contrast ☐ With & Without

☐ Abdominal/Pelvic Arteries
☐ Abdominal Aorta & Runoff
☐ Aorta - Thoracic
☐ Aorta - Abdominal
☐ Circle of Willis (Head)
☐ Carotids (Neck)
☐ MRV Brain
☐ Portal Vein - Inf. Vena Cava
☐ Upper Extremity L R
☐ Lower Extremity L R

ATTORNEY

ICD-10 Code / Diagnosis: _____
Attorney Name: _____
Attorney Number: _____ Date of Injury: _____

☐ Work Comp ☐ MVA ☐ Slip & Fall

PHYSICIAN

☐ The interpreting physician may modify the test design; including the number of views, thickness of tomographic sections, and use or non-use of contrast.

Physician Signature: _____ Date: _____

Physician Name: _____ Physician Phone: _____ Physician Fax: _____

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