Central Imaging of Arlington

3100 Matlock Rd, Ste 105, Arlington, TX 76015
Phone 817.543.2412 Fax 817.543.2663 Fax 817.200.2666

☐ Please compare to previous study dated________________

Date____|____|____ Sex ☐ Male ☐ Female ☐ STAT ☐ STAT Verbal Phone Call________________

Name____ DOB ____|____|____

Phone ________________________ Insurance Name ________________________ Ins. ID #________________

Diagnosis ICD10 ____

Ref. Physician ________________________ Phys. Phone ________________ Phys. Fax ________________

Send CD w/Pt ☐ Deliver CD ☐ Attorney ________________________ Ph________________ Fax ____________

For all MRIs, Cat Scans and Nuclear Scans please fax order, patient demographic, insurance, and clinical notes to 817.543.2663

If you have precerted, please supply authorization number________________________________

CIA to precert ☐ ____

X-RAYS

- ☐ Abdomen (KUB)
- ☐ Abdomen (Flat/Erect)
- ☐ Ankle R ☐ L ☐
- ☐ Cervical 3V—5V—7V
- ☐ Chest
- ☐ Clavicle R ☐ L ☐
- ☐ Elbow R ☐ L ☐
- ☐ Facial Bones
- ☐ Femur R ☐ L ☐
- ☐ Fingers R ☐ L ☐ Specify
- ☐ Foot R ☐ L ☐
- ☐ Forearm R ☐ L ☐
- ☐ Hand R ☐ L ☐
- ☐ Heel R ☐ L ☐
- ☐ Hip R ☐ L ☐
- ☐ Humerus R ☐ L ☐
- ☐ Knee R ☐ L ☐
- ☐ Lumbar 3V—5V—7V
- ☐ Pelvis 1V
- ☐ Ribs R ☐ L ☐
- ☐ Sacroiliac Joints
- ☐ Sacrum, Coccyx
- ☐ Scapula R ☐ L ☐
- ☐ Shoulder R ☐ L ☐
- ☐ Sinus 3
- ☐ Skull
- ☐ Soft Tissue Neck
- ☐ Sternum
- ☐ TM Joints
- ☐ Thoracic Spine
- ☐ Toes R ☐ L ☐ Specify
- ☐ Wrist R ☐ L ☐
- ☐ Other ______________

FLUORO

- ☐ Upper GI
- ☐ Barium Swallow

PAIN MANAGEMENT & SPECIAL PROCEDURES

- ☐ E.S.I. ☐ T ☐ Cerv ☐ L
- ☐ Arthrogram
- ☐ Wrist ☐ R ☐ L
- ☐ Hip ☐ R ☐ L
- ☐ Knee ☐ R ☐ L
- ☐ Shoulder ☐ R ☐ L
- ☐ Myelogram
  - ☐ Cerv ☐ L ☐ T
- ☐ Discogram
  - ☐ Cerv ☐ L
- ☐ Facet Injection
  - ☐ Cerv ☐ L
- ☐ Nerve Root Block
  - ☐ Cerv ☐ L
- ☐ Other______________

ULTRASOUND

- ☐ Abdomen
- ☐ Abdomen, Aorta
- ☐ Breast Male/Female
- ☐ Pelvic
- ☐ Popliteal Fossa
- ☐ Renal
- ☐ Testicular/Scrotal
- ☐ Thyroid
- ☐ Chest-Arm-Leg Ext
- ☐ Other______________

BONE DENSITOMETRY

- ☐ Bone Density (DEXA-SCAN)

NUCLEAR

- ☐ Bone Scan, (Specify Area)
- ☐ Bone Scan, Whole Body
- ☐ Bone Scan With Flow
- ☐ Disida/Hida (Hepatobiliary)
- ☐ Liver/Spleen
- ☐ Renal
- ☐ Thyroid/Uptake

CAT SCAN

- ☐ With Contrast Oral
- ☐ W/Out Contrast I.V.
- ☐ W/and W/O Contrast
- ☐ Abdomen & Pelvis
- ☐ Abdomen (Kidney Stone) W/O
- ☐ Abdomen
- ☐ Chest
- ☐ Cervical
- ☐ Facial Bone
- ☐ Head
- ☐ Hip ☐ R ☐ L
- ☐ IAC's
- ☐ Lumbar
- ☐ Lower Extremity ☐ R ☐ L
- ☐ Facial
- ☐ Orbits
- ☐ Pelvis
- ☐ Soft Tissue Neck
- ☐ Temporal Bone/Mastoid
- ☐ Thoracic
- ☐ Upper Extremity ☐ R ☐ L
- ☐ Other ________________

DOPPLER ULTRASOUND

- ☐ Carotid
- ☐ Arterial Ext ☐ R ☐ L
- ☐ Venous Ext ☐ R ☐ L

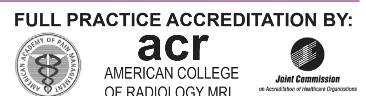
☐ BUN & CREATININE TEST

MRI

- ☐ Sedation Requested
- ☐ With Contrast
- ☐ W/Out Contrast
- ☐ W/and W/O Contrast
- ☐ Abdomen
- ☐ Abdomen w/MRCP
- ☐ Ankle ☐ R ☐ L
- ☐ Brain
- ☐ Brain/MRA
- ☐ Brachial Plexus
- ☐ Breast Male
- ☐ Carotid/MRA
- ☐ Cervical
- ☐ Elbow ☐ R ☐ L
- ☐ Hip ☐ R ☐ L
- ☐ Knee ☐ R ☐ L
- ☐ Lumbar
- ☐ Lower Ext. Non-Joint
- ☐ Orbits
- ☐ Pelvis
- ☐ Shoulder ☐ R ☐ L
- ☐ Thoracic
- ☐ TMJ
- ☐ Upper Ext. Non - Joint
- ☐ Wrist ☐ R ☐ L
- ☐ Other ______________

DEXA and all X-Rays (are done on a walk in basis), MRI, and Ultrasound CT, NM are by appointment only.
Payment is expected at the time services are rendered. To schedule call 817-543-2412

FULL PRACTICE ACCREDITATION BY:



Your study will yield the optimum results when you follow the instructions provided below.
We appreciate your cooperation!

CHECK TYPE OF STUDY	TYPE OF STUDY	PREP
❑	UPPER GI	NOTHING BY MOUTH AFTER MIDNIGHT.
❑	CT ABDOMEN / PELVIS	FASTING: NOTHING TO EAT OR DRINK 4 HOURS BEFORE TEST. BARIUM DRINK PROVIDED ONE HOUR BEFORE TEST.
❑	SONOGRAM OR GALLBLADDER OR ABDOMEN	NOTHING BY MOUTH AFTER MIDNIGHT OR 6 HOURS BEFORE TEST.
❑	PELVIC SONOGRAM	TWO HOURS BEFORE EXAM, DRINK TWO QUARTS OF LIQUID WITHOUT VOIDING.

Central Imaging of Arlington

Located behind the Time & Temperature Sign