OVAL MRI
❑ "One size fits all"

HIGH-V
❑ 80 CM

6207 Cortez Road W.
Bradenton, FL 34210

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BIC
Bowes Imaging Center

SAME DAY APPOINTMENTS

AVAILABLE EVENINGS & WEEKENDS

Patient's Name: _____ Physician's Name: _____

D.O.B.: _____ Physician's Signature: _____

Indication: _____ CC: _____

Diagnosis: _____ **Appointment On:** _____

MRI - NEURO/BODY

	Without	With/Without	Contrast at RAD Discretion
VEN BOLD	❑		
DTI (Diffusion Tensor Imaging)	❑		
BRAIN	❑	❑	❑
MRV BRAIN	❑	❑	❑
IAC'S	❑	❑	❑
PITUITARY	❑	❑	❑
ORBITS	❑	❑	❑
CERVICAL SPINE	❑	❑	❑
THORACIC SPINE	❑	❑	❑
LUMBAR SPINE	❑	❑	❑
NECK (SOFT TISSUE)	❑	❑	❑
BREAST MRI R L	❑	❑	❑
CHEST	❑	❑	❑
ABDOMEN	❑	❑	❑
PELVIS	❑	❑	❑
TMJ	❑	❑	❑

MRI - MUSCULOSKELETAL

	Without	With/Without	Contrast at RAD Discretion
SHOULDER R L	❑	❑	❑
ELBOW R L	❑	❑	❑
WRIST R L	❑	❑	❑
HAND R L	❑	❑	❑
HIP R L	❑	❑	❑
KNEE R L	❑	❑	❑
ANKLE R L	❑	❑	❑
FOOT R L	❑	❑	❑

MRA - ANGIOGRAPHY

	Without	With/Without
CIRCLE OF WILLIS	❑	
CAROTID ARTERIES	❑	❑
AORTA		
THORACIC		❑
ABDOMINAL		❑
RENAL ARTERIES		❑
LOWER EXTREMITY-RUNOFF R L		❑
UPPER EXTREMITIES R L		❑

DEXA

❑ BONE DENSITY ❑ OTHER: _____

X-RAY

CHEST PA & LAT	❑	SHOULDER	❑ R L
ABDOMEN, KUB	❑	ELBOW	❑ R L
ABDOMINAL SERIES	❑	WRIST	❑ R L
PELVIS	❑	HAND	❑ R L
C-SPINE	❑	HIP	❑ R L
T-SPINE	❑	KNEE	❑ R L
L-SPINE	❑	ANKLE	❑ R L
		FOOT	❑ R L

CT

❑ Without ❑ With/Without ❑ Contrast at Radiologist Discretion

HEAD ❑ Oral Contrast
- ❑ HEAD ❑ SINUS ❑ TMJ
- ❑ MANDIBLE ❑ ORBITS ❑ NECK (SOFT TISSUE)
- ❑ TEMPORAL BONE ❑ OTHER _____

SPINE
- ❑ CERVICAL ❑ THORACIC ❑ SACRUM/COCCYX
- ❑ LUMBAR ❑ OTHER _____

MUSCULOSKELETAL
- ❑ ANKLE: R L ❑ KNEE: R L ❑ HIP: R L
- ❑ ELBOW: R L ❑ SHOULDER: R L ❑ OTHER _____

BODY
- ❑ CHEST ❑ RENAL COLIC ❑ UROGRAM
- ❑ LOW DOSE CT CHEST ❑ ABDOMEN ❑ PELVIS

CTA
- ❑ ABDOMEN ❑ PULMONARY ARTERIES ❑ THORAX
- ❑ CAROTID ❑ OTHER _____

❑ CT CALCIUM SCORE
SERVICE NOT COVERED BY INSURANCE:

ULTRASOUND

❑ CAROTIDS	❑ EXTREMITY	❑ PELVIC
❑ RENAL DOPPLER	❑ ABDOMINAL	❑ BREAST
❑ RENAL ULTRASOUND	❑ AAA	

❑ VENOUS: LEG: R L BILAT ARM: R L BILAT
❑ ARTERIAL: LEG: R L BILAT ARM: R L BILAT

3-D DIGITAL MAMMOGRAPHY

❑ (3-D) SCREENING
❑ (3-D) DIAGNOSTIC BILATERAL US IF NEC ❑ Y ❑ N
❑ (3-D) DIAGNOSTIC UNILATERAL ❑ RIGHT ❑ LEFT US IF NEC ❑ Y ❑ N
ADDITIONAL VIEWS:

❑ STAT FAX to: _____ ❑ Report Only ❑ Films with Patient ❑ CD with Patient

❑ STAT CALL to: _____ ❑ Films & Report to Office by: _____