

OVAL MRI

Check here for oval



HIGH-V

80 CM (Bradenton Only)

3900 Clark Road, Bldg. P
Sarasota, FL 34233

Phone (941) 924-8600

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www.bowesimagingcenter.com

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

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

Indication: _____ CC: _____

Diagnosis: _____ Appointment On: _____

SAME DAY APPOINTMENTS

AVAILABLE EVENINGS & WEEKENDS

MRI - NEURO/BODY

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

MRI - MUSCULOSKELETAL

	Without	With/Without	Contrast at RAD Discretion
SHOULDER R L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ELBOW R L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WRIST R L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HAND R L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIP R L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
KNEE R L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ANKLE R L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FOOT R L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MRA - ANGIOGRAPHY

	Without	With/Without
CIRCLE OF WILLIS	<input type="checkbox"/>	
CAROTID ARTERIES	<input type="checkbox"/>	<input type="checkbox"/>
AORTA		<input type="checkbox"/>
THORACIC		<input type="checkbox"/>
ABDOMINAL		<input type="checkbox"/>
RENAL ARTERIES		<input type="checkbox"/>
LOWER EXTREMITY-RUNOFF R L		<input type="checkbox"/>
UPPER EXTREMITIES R L		<input type="checkbox"/>

X-RAY

CHEST PA & LAT	<input type="checkbox"/>	SHOULDER	<input type="checkbox"/>	R	L
ABDOMEN, KUB	<input type="checkbox"/>	ELBOW	<input type="checkbox"/>	R	L
ABDOMINAL SERIES	<input type="checkbox"/>	WRIST	<input type="checkbox"/>	R	L
PELVIS	<input type="checkbox"/>	HAND	<input type="checkbox"/>	R	L
C-SPINE	<input type="checkbox"/>	HIP	<input type="checkbox"/>	R	L
T-SPINE	<input type="checkbox"/>	KNEE	<input type="checkbox"/>	R	L
L-SPINE	<input type="checkbox"/>	ANKLE	<input type="checkbox"/>	R	L
		FOOT	<input type="checkbox"/>	R	L
OTHER:	_____				

CT

<input type="checkbox"/> Without	<input type="checkbox"/> With/Without	<input type="checkbox"/> Contrast at Radiologist Discretion
HEAD <input type="checkbox"/> Oral Contrast		
<input type="checkbox"/> HEAD	<input type="checkbox"/> SINUS	<input type="checkbox"/> TMJ
<input type="checkbox"/> MANDIBLE	<input type="checkbox"/> ORBITS	<input type="checkbox"/> NECK (SOFT TISSUE)
<input type="checkbox"/> TEMPORAL BONE	<input type="checkbox"/> OTHER _____	
SPINE		
<input type="checkbox"/> CERVICAL	<input type="checkbox"/> THORACIC	<input type="checkbox"/> SACRUM/COCCYX
<input type="checkbox"/> LUMBAR	<input type="checkbox"/> OTHER _____	
MUSCULOSKELETAL		
<input type="checkbox"/> ANKLE: R L	<input type="checkbox"/> KNEE: R L	<input type="checkbox"/> HIP: R L
<input type="checkbox"/> ELBOW: R L	<input type="checkbox"/> SHOULDER: R L	<input type="checkbox"/> OTHER _____
BODY		
<input type="checkbox"/> CHEST	<input type="checkbox"/> RENAL COLIC	<input type="checkbox"/> UROGRAM
<input type="checkbox"/> ABDOMEN	<input type="checkbox"/> PELVIS	<input type="checkbox"/> OTHER _____
CTA		
<input type="checkbox"/> ABDOMEN	<input type="checkbox"/> PULMONARY ARTERIES	<input type="checkbox"/> THORAX
<input type="checkbox"/> CAROTID	<input type="checkbox"/> OTHER _____	
<input type="checkbox"/> CT CALCIUM SCORE		
SERVICE NOT COVERED BY INSURANCE:		

ULTRASOUND

<input type="checkbox"/> CAROTIDS	<input type="checkbox"/> EXTREMITY	<input type="checkbox"/> PELVIC
<input type="checkbox"/> RENAL DOPPLER	<input type="checkbox"/> ABDOMINAL	<input type="checkbox"/> BREAST
<input type="checkbox"/> RENAL ULTRASOUND	<input type="checkbox"/> AAA	
<input type="checkbox"/> VENOUS: LEG: R L BILAT	ARM: R L BILAT	
<input type="checkbox"/> ARTERIAL: LEG: R L BILAT	ARM: R L BILAT	
OTHER:	_____	

STAT FAX to: _____

Report Only Films with Patient CD with Patient

STAT CALL to: _____

Films & Report to Office by: _____