Medical Imaging

MWHC — In partnership with Radiologic Associates of Fredericksburg

For scheduling or cancellations, please call 540-741-XRAY (9729). Ask about our 0% interest payment plans.

Please fax this form to: 540-741-7679 or Email: MIFschedulers@mwhc.com

Please include insurance cards and contact number.

Same day appointments available pending insurance authorization.

DISCLAIMER/AUTHORIZATION

Medical Imaging of Fredericksburg, Medical Imaging at Lee's Hill, Medical Imaging of North Stafford, MIKG, and the Imaging Center for Women are authorized and have my permission to add or delete any additional imaging procedures required to appropriately diagnose the patient I am referring.

CDS Information (required for all MRI, CT, and PET Studies)
Session ID______ Score______ Vendor/G-Code______ Adherence Modifier______

☐ **MEDICAL IMAGING OF FREDERICKSBURG**
1201 Sam Perry Blvd, Ste 102 Fredericksburg, VA 22401

☐ **MEDICAL IMAGING OF NORTH STAFFORD**
125 Woodstream Blvd, Suite 109 Stafford, VA 22556

☐ **MEDICAL IMAGING AT LEE'S HILL**
10401 Spotsylvania Ave, Ste 101 Fredericksburg, VA 22408

☐ **IMAGING CENTER FOR WOMEN***
1300 Hospital Dr, Suite 100 Fredericksburg, VA 22401

☐ **MEDICAL IMAGING OF KING GEORGE**
11131 Journal Parkway King George, VA 22485

☐ **IMAGING CENTER FOR WOMEN NORTH STAFFORD**
125 Woodstream Blvd, Suite 101 Stafford, VA 22556

Date: ______

Patient Name: ______

Phone No: ______ Date of Birth: ______

History/Diagnosis: ______

Dr. Fax No: ______

Requested by Dr. ______ Dr. Signature: ______

PLEASE PERFORM ISTAT BUN/ CREATININE AS NEEDED ☐

CT SCREENINGS

☐ Heart Scan ☐ Virtual Colonoscopy
☐ Low Dose CT Lung Cancer Screening Annual
☐ Low Dose CT Lung Cancer Screening Follow Up- Lung Rad 3, a 6 month follow up was recommended
☐ Low Dose CT Lung Cancer Screening Follow Up- Lung Rad 4, a 3 month follow up was recommended

For an initial/baseline Low Dose CT Lung Cancer Screening, you must use the LDCT ordering form

CT SCAN

SPECIFY IV CONTRAST
☐ Yes ☐ No ☐ At RAD Discretion
☐ w/ and w/o contrast

☐ Sinuses
☐ Head
☐ Soft Tissue Neck
☐ Temporal Bone/ Middle Ear
☐ Chest
☐ Abdomen
☐ Pelvis
☐ Spine
 ☐ Cervical
 ☐ Lumbar
 ☐ Thoracic

☐ Extremities *(specify)* ______
 ☐ Left ☐ Right
☐ Arthrogram
☐ 3D Recons
☐ Renal Stone Screening
☐ 4D Parathyroid
☐ Enterography
☐ Scanogram
☐ Urogram with 3D Imaging
☐ Facial/Maxillary

☐ CTA Head
☐ CTA Neck
☐ CTA Chest PE
☐ CTA Aorta for Dissection *(CTA Chest & CTA Abdomen)*

☐ CTA Abdomen
☐ CTA Abdomen & Pelvis
☐ CTA Run Off Bilateral *(includes abdomen)*
☐ CTA Chest for TAA (ascending TAA w Gating)

PET-CT SCAN

☐ 78814 PET-CT Tumor, limited area
☐ 78815 PET-CT Tumor, skull base to mid thigh
☐ 78816 PET-CT Tumor, whole body
☐ 78459 PET Myocardium, metabolic evaluation
☐ 78608 PET Brain, metabolic evaluation
☐ Initial ☐ Restaging

To schedule a PET-CT Scan, please call:
540-741-4PET or 1-866-MIF-4PET (866-643-4738)

DIAGNOSTIC (PLAIN FILMS)

No appointment necessary — See reverse side for Walk-in locations

☐ Abdomen
 ☐ Flat
 ☐ Flat & Erect
☐ Chest
 ☐ PA & LAT
 ☐ PA Only
☐ Ribs ___L ___R
☐ AP Pelvis
 ☐ Rt. Hip w/ Pelvis
 ☐ Lt. Hip w/ Pelvis
☐ Spine
 ☐ Cervical
 ☐ Lumbar
 ☐ Thoracic
 ☐ Scoliosis Series

☐ Sinuses
☐ Extremities
 ☐ Shoulder ___L ___R
 ☐ Humerus ___L ___R
 ☐ Elbow ___L ___R
 ☐ Forearm ___L ___R
 ☐ Wrist ___L ___R
 ☐ Hand ___L ___R
 ☐ Femur ___L ___R
 ☐ Knee ___L ___R
 ☐ Tib/Fib ___L ___R
 ☐ Ankle ___L ___R
 ☐ Foot ___L ___R
☐ Metastatic Bone Survey *Appointment Necessary*
☐ Other *(specify)* ______

UROLOGICAL/OB

☐ IVP ☐ HSG

See CT Scanning for other renal imaging exams

GASTROINTESTINAL TRACT

☐ Barium Enema ☐ Small Bowel
☐ Esophagram ☐ UGI

ULTRASOUND

☐ Abdominal Complete
☐ Abdominal Limited Single Organ (______)
☐ Aorta
☐ Appendix
☐ Infant Head (6 mo. & under)
☐ Infant Spine (6 mo. & under)
☐ Infant Hip (6 mo. & under)
☐ Liver Elastography *MIF only*
☐ Musculoskeletal (MSK)
☐ Neck (Lymph Nodes)
☐ Renal/Bladder
☐ Scrotum
☐ Thyroid/Parathyroid

☐ Pelvic
☐ Pelvic w/transvaginal
☐ Pelvic Transvaginal Only
☐ Obstetric
☐ Obstetric w/transvaginal
☐ Obstetric Transvaginal Only
☐ Clinically established EDD incorporating prior ultrasound: ____/____/20____
☐ LMP: ____/____/____
☐ Uncertain LMP
☐ Biophysical Profile
☐ Duplex/Carotid
☐ Venous Doppler:
 ☐ Lower ☐ Upper
 ☐ Left ☐ Right
 ☐ Bilateral
☐ Other ______

MRI APPOINTMENTS: PLEASE ARRIVE 30 MINS EARLY

MRI ABDOMINAL

SPECIFY ☐ w/o ☐ w/wo ☐ At RAD discretion

MRI ATTN: ______ ☐ MRCP with 3D Imaging ☐ MRI Enterogram

MRI BREAST

☐ Screening ☐ Implant(s)
☐ Abbreviated Breast Screening

MRI PELVIS

SPECIFY ☐ w/o ☐ w/wo ☐ At RAD discretion

☐ Bony Pelvis
☐ Uterine/Ovarian
☐ Defecogram
☐ Prostate
☐ Bladder/Urethra
☐ Soft Tissue
☐ Other: ______

MRI NEURO

SPECIFY ☐ w/o ☐ w/wo ☐ At RAD discretion

☐ Brain ATTN: ______
☐ Cervical
☐ Thoracic
☐ Lumbar
☐ Pelvis Plexus
☐ Brachial Plexus
☐ Chest ATTN: ______

MRA

☐ Brain
☐ Abdominal
☐ Runoff
☐ Chest
☐ Neck ATTN: ______

MRI ORTHO

SPECIFY ☐ w/o ☐ w/wo ☐ At RAD discretion

☐ Exam ______ ☐ Left ☐ Right

FOR MIF USE ONLY
☐ Sheath Placement