elite diagnostic imaging

9758 E 21st St N Suite 103
Wichita, KS 67206
P: 316-295-3794
F: 316-242-2476

Patient Name	DOB	Height	Weight

Telephone Home	Work	Mobile

Referring Physician	Physician Phone Number

Insurance Camer	Member ID Number	Group Number

Date of Injury	Claim Number	Adjuster

Copy of Images	☐ CD ☐ Send with Patient ☐ Send to Office ☐ None	Insurance Authorization Required ☐ Yes ☐ No If Yes, please provide: Patient demographics, insurance card, ID cards, relevant office notes.

☐ **STAT REPORT (EMERGENT/URGENT CARE REFERRAL)**
Call Report to Dr:_____ Phone Number (Req.) _____Fax: _____

CT

☐ Brain/Head
☐ Orbits
☐ IAC's / Temporal Bones
☐ Sinuses
☐ Facial Bones
☐ Neck, Soft Tissue
☐ Chest
☐ Chest/High Resolution
☐ Low Dose CT Chest/Lung Cancer Screening
☐ Abdomen
☐ Pelvis
☐ Enterography
☐ Renal Stone Protocol
☐ Urogram
☐ Renal Mass
☐ Pancreas
☐ Liver
☐ Spine-Cervical
☐ Spine-Thoracic
☐ Spine-Lumbar
☐ Spine-Sacrum/Coccyx
☐ Extremity □ Right □ Left
☐ Specify_____
☐ Other _____
☐ With Contrast
☐ Without Contrast
☐ With and Without Contrast
☐ 3D Rendering
☐ CAC Scorn
☐ CTA Specify Area _____

3T MRI

☐ Brain ☐ DTI
☐ Pituitary
☐ MS
☐ Seizure
☐ Orbits
☐ Trigeminal
☐ IAC's
☐ MRA Brain
☐ MRV Brain
☐ Soft Tissue Neck
☐ Brachial Plexus
☐ Spine-Cervical
☐ Spine-Thoracic
☐ Spine-Lumbar
☐ Pelvis/Sacrum/SI Joints
☐ Pelvis/Hip □ Right □ Left
☐ Pelvis/ ST or Female or Prostate
Specify _____
☐ Breast □ Dynamic □ Silicone Implant
☐ Abdomen
☐ Enterography
☐ Foot □ Right □ Left
☐ Knee □ Right □ Left
☐ Ankle □ Right □ Left
☐ Extremity □ Right □ Left
Specify _____
☐ Other _____
☐ With & Without Contrast
☐ Without Contrast
☐ Post-Arthogram MRI
□ Right □ Left
Specify _____

XRAY

☐ KUB
☐ Abdomen 2 Views
☐ Pelvis
☐ Chest PA and Lateral
☐ Sinus Series
☐ Hip □ Right □ Left
☐ Cervical Spine
_____ Views
☐ Thoracic Spine
_____ Views
☐ Lumbar Spine
_____Views
☐ Ribs □ Right □ Left
☐ Sacrum & Coccyx
☐ Skull Series 4 Views
☐ Extremity □ Right □ Left
☐ Specify _____
☐ Other _____
☐ Orbits for Foreign Body
Pre-MRI Screening
☐ Arthrogram, Extremity Joint
□ Right □ Left
Specify _____

Dx

Physician/Provider Signature: **Order Date:**

CT, MRI, and XRAY PATIENTS

1. If you are allergic to **CT iodine contrast** or **MRI gadolinium contrast,** please notify our office prior to your exam.
2. Please arrive **30 minutes** prior to your exam time to allow time for paperwork.
Please arrive **1 hour** prior to your exam time if your exam requires you to drink oral contrast.
3. Please remove all jewelry prior to your CT, MRI, or XRAY exam.
4. CT and XRAY patients: please wear comfortable clothing with no metal buttons, zippers, or snaps, if possible.
5. MRI patients: everyone will be changed into a gown and shorts for your exam.

THE FOLLOWING EXAMS REQUIRE PREPARATION

If you are scheduled for one of the following CT exams, nothing to eat or drink **4 hours** prior to your exam time. You may take medications with small amounts of water.

CT EXAMS: ABDOMEN & PELVIS ABDOMEN ONLY PELVIS ONLY

CT or MRI ENTEROGRAPHY: NOTHING TO EAT OR DRINK 6 HOURS PRIOR TO EXAM

MRI Abdomen MRCP looking at the gallbladder, nothing to eat or drink 4 hours prior. Do not drink even water prior to this exam or it will have to be rescheduled.

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