El Portal IMAGING CENTER

3365 G Street Suite 100
Merced CA 95340
Phone: (209) 384-4250
FAX: (209) 384-4269

Patient Name _____ Date of Birth _____ Height _____ Weight ____
Patient Phone # _____ Appointment Date _____ Arrival Time _____
Referring Provider _____
Office Phone ( ) _____ Fax ( ) _____

SPECIAL INSTRUCTIONS

☐ Routine ☐ Phone Report ☐ Send Films ☐ ASAP ☐ STAT Please provide **PHONE NUMBER** for use **AFTER 5 PM** _____

Diagnosis/History: _____

MRI	**1st Floor Registration**		
☐ Brain (routine)	☐ Cervical Spine (routine)	☐ Knee Right / Left	☐ Abdomen (includes liver, spleen,
☐ Brain (without contrast)	☐ Thoracic Spine (routine)	☐ Shoulder Right / Left	pancreas, gallbladder)
☐ IAC's	☐ Lumbar Spine (routine)	☐ Ankle Right / Left	☐ MRCP
☐ Pituitary	☐ without & with Contrast	☐ Hip Right / Left	☐ Pelvis
☐ MRA Circle of Willis (Brain)		☐ Elbow Right / Left	☐ MRA Abdomen ☐ MRA Renals
☐ MRA Carotids (Neck)	☐ TMJ's	☐ Wrist Right / Left	☐ MRA Abdominal Aorta w/runoff
☐ Neck Soft Tissue	☐ Breast Unilateral Right / Left	☐ Extremity Upper / Lower	
	☐ Breast Bilateral	(specify extremity) _____	☐ Other _____
CT 1st Floor	**1st Floor Registration**		
☐ Brain (routine)	☐ Chest (routine)	☐ Abdomen (routine)	☐ Joint Right / Left
☐ Brain (without contrast)	☐ Chest (without contrast)	☐ Abdomen (without contrast)	(specify joint) _____
☐ Sinuses	☐ Chest (High Resolution)	☐ Pelvis (routine)	☐ Bone Right / Left
☐ Mastoids	☐ Thoracic Aorta	☐ Pelvis (without contrast)	(specify area) _____
☐ Orbits	☐ Abdominal Aorta		☐ CT Arthrogram
☐ Facial Bones	☐ Abdominal Aorta w/runoff	☐ CT Biopsy	(specify joint) _____
☐ Neck Soft Tissue		(specify organ/area) _____	☐ Other
Nuclear Medicine	**1st Floor Registration**		
☐ Bone Scan (whole body,limited,3 phase)	☐ Liver/Spleen	☐ Thyroid scan only (99mTc-pertechnetate)	☐ VQ Lung Scan
☐ Hepatobiliary (HIDA) - (with EF images)	☐ Helicobacter Pyloric Breath Test	☐ Thyroid scan with Uptake (123-Iodine)	☐ Perfusion Lung Scan only
☐ Renal Scan (MAG-3) with Captopril	☐ Gastric emptying (Solid) (Dual Phase)	☐ Parathyroid scan	☐ Myocardial Perfusion Study
☐ Renal Scan (MAG-3) with Lasix	☐ Meckel's Diverticulum Imaging	☐ Thyroid Metastases Study (131-Iodine)	☐ MUGA (Resting Cardiac Assmt)
☐ White Blood Cell (Ceretc WBC's)	☐ Gastrointestinal Bleed Study	☐ Sentinel Node Localization Study	☐ Bone Marrow Imaging
☐ White Blood Cell (111-Indium WBC's)	☐ Somatostatin Receptor (Octreotide)	☐ Cisternography	☐ Other _____
PET (please indicate if exam is for) Diagnosis __ Staging __ Restaging __			**1st Floor Registration**
☐ Breast Cancer	☐ Colorectal Cancer	☐ Head & Neck Cancer	☐ Lung Cancer
☐ Lymphoma	☐ Melanoma	☐ Thyroid Cancer	☐ Brain
Diagnostic Radiology (Specify body part including R,L, and Bilateral			**2nd Floor Registration**
☐ Chest (1 view)	☐ Thoracic Spine	☐ Hip Right / Left	☐ Nasal Bones
☐ Chest (2 view)	☐ Lumbar Spine (complete)	☐ Femur Right / Left	☐ Mandible
☐ Ribs Right / Left / Bilateral	☐ Lumbar Spine (limited)	☐ Knee Right / Left	☐ Shoulder Right / Left
☐ Neck Soft Tissue	☐ Sacrum & Coccyx	☐ Tibia & Fibula Right / Left	☐ Humerus Right / Left
☐ Sinus Series	☐ Sacro-Iliac Joints	☐ Ankle Right / Left	☐ Elbow Right / Left
☐ Abdomen (1V)	☐ Scoliosis Series	☐ Foot Right / Left	☐ Forearm Right / Left
☐ Abdomen (complete)	☐ Bone Survey	☐ Os Calcis (Heel) Right / Left	☐ Wrist Right / Left
☐ Cervical Spine (complete)	☐ Bone Age	☐ Other _____ Right / Left	☐ Hand Right / Left
☐ Cervical Spine (limited)	☐ Clavicle	☐ Skull Complete / Limited	☐ Fingers Right / Left
	☐ Sternum	☐ Orbits ☐ Facial Bones	☐ Other _____
Ultrasound	**2nd Floor Registration**		
☐ Abdomen	☐ Thyroid	Peripheral Vascular	☐ Breast Right / Left
☐ Renal	☐ Testicular	☐ Venous Upper Extremity Right / Left	☐ Other _____
☐ Pelvis ☐ Pelvis with E/V		☐ Venous Lower Extremity Right / Left	
☐ Obstetrical (OB)	☐ Abdominal Aorta	☐ Arterial Upper Extremity Right / Left	☐ ECHOCARDIOGRAM
	☐ Carotid	☐ Arterial Lower Extremity Right / Left	Interpreting Physician _____
Mammography	**2nd Floor Registration**		
☐ Screening Bilateral / Unilateral R / L	☐ Diagnostic Bilateral / Unilateral R / L	☐ Stereotactic Breast Biopsy Right / Left	

Provider Signature _____ Date _____

Important Patient information on the back of this form.

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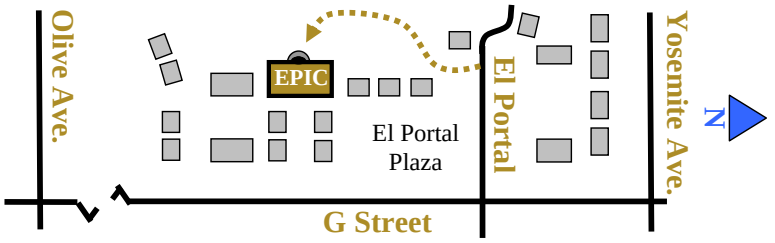
At El Portal Plaza
3365 G Street Suite 100
(209) 384-4250



Instructions

- Be sure to follow instructions for your exam preparation. Please bring the following items with you to your appointment
  - ⇨ Insurance card
  - ⇨ Physician's order
  - ⇨ Prior imaging/x-ray/mammogram examination
- Please be sure any precertification requirements of your healthplan are met prior to your appointment.
- You will be asked to arrive 15 - 30 minutes prior to your appointment.
- Exam results will be sent to your physician within 48 hours.
- If you need your films for an appointment, please call us 24 hours in advance.
- If you have any questions about preparation or your exam, please contact us at the phone number listed above.

Exam Preparations

- **MRI**
  - ⇨ Assure that you **Do NOT** have a pacemaker or brain aneurysm clip. Notify staff if you have any metal anywhere in your body. Please arrive well-hydrated (2-4 glasses of water) as some exams may require an IV contrast injections.
- **CT**
  - ⇨ Please drink 4-6 glasses of water starting four hours prior to your exam. **Do NOT** eat anything for at least three hours prior to the exam.
- **NUCLEAR MEDICINE & PET EXAMINATIONS**
  - ⇨ Please call office for exam instructions. Please avoid contact with pregnant women & small children for 24 hours after your injection.
- **XRAY**
  - ⇨ Please call office for exam instructions.
- **ULTRASOUND**
  - ⇨ **ABDOMEN /GALLBLADDER/ KIDNEY/AORTA ULTRASOUND:** Please eat a **FAT FREE meal** the evening before your exam. **Do NOT** eat or drink anything after midnight prior to the exam.
  - ⇨ **PELVIC/OB ULTRASOUND:** Drink 4 glasses of water one hour prior to appointment. **Do NOT** empty bladder. Bladder must be full for exam.
- **MAMMOGRAM:**
  - ⇨ **Do NOT** use deodorant, powder, or perfume prior to exam.

** If you **ALLERGIC to IODINE** or **IVP DYE,**
notify our office **PRIOR** to your appointment
** If you are **DIABETIC, Do NOT** take **GLUCOPHAGE**
for **48 HOURS AFTER** your exam