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 Boynton Beach • Wellington • Delray Beach
561.739.9674
 Fax 561-739-9688

Appointment Date:

Date: _____

Time: _____

Please check if transportation is required

Patient Information

Patient's Name: _____ DOB: _____ SS#: _____
 Address: _____ Place of Work: _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____

Insurance Information

Insurance Name: _____ Phone: _____
 Group #: _____ Policy #: _____ ID #: _____
 Claim #: _____ Authorization #: _____ Date of Accident: _____
 Attorney Name: _____ Phone: _____

MRI	Open MRI - Boynton only High Field MRI - Wellington/Delray Beach			
	w/o	with w/o	R	L
Brain	<input type="checkbox"/>	<input type="checkbox"/>		
IAC	<input type="checkbox"/>	<input type="checkbox"/>		
Orbit	<input type="checkbox"/>	<input type="checkbox"/>		
Pituitary	<input type="checkbox"/>	<input type="checkbox"/>		
Soft Tissue Neck	<input type="checkbox"/>	<input type="checkbox"/>		
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>		
Liver	<input type="checkbox"/>	<input type="checkbox"/>		
Kidney	<input type="checkbox"/>	<input type="checkbox"/>		
MRCP	<input type="checkbox"/>	<input type="checkbox"/>		
C-Spine	<input type="checkbox"/>	<input type="checkbox"/>		
T-Spine	<input type="checkbox"/>	<input type="checkbox"/>		
L-Spine	<input type="checkbox"/>	<input type="checkbox"/>		
Sacrum/Coccyx	<input type="checkbox"/>	<input type="checkbox"/>		
Pelvis	<input type="checkbox"/>	<input type="checkbox"/>		
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hand/Fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leg (femur)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leg (tib/fib)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ankle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot/Toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other				

CT	Wellington Only		
	w	w/o	with w/o
Brain / Head	<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"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>	
IAC Temporal	<input type="checkbox"/>	<input type="checkbox"/>	
Soft Tissue Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C-Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T-Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L-Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other			
<input type="checkbox"/> Facial Bones			
<input type="checkbox"/> Extremity <input type="checkbox"/> R <input type="checkbox"/> L			
<input type="checkbox"/> Angiography			
<input type="checkbox"/> 3D Reconstruction			
<input type="checkbox"/> Virtual Colonoscopy			

Ultrasound	Wellington Only
Carotid	<input type="checkbox"/>
ABD-Liver / GB / Pancreas	<input type="checkbox"/>
Abdomen - Complete (includes spleen)	<input type="checkbox"/>
Pancreas / Retroperitoneal	<input type="checkbox"/>
Venous Doppler	<input type="checkbox"/>
<input type="checkbox"/> Unilateral <input type="checkbox"/> Bilateral	
<input type="checkbox"/> R <input type="checkbox"/> L	
<input type="checkbox"/> Lower ext. <input type="checkbox"/> Upper ext.	
Arterial Doppler	<input type="checkbox"/>
<input type="checkbox"/> Lower extremity w/ ABI	
Renal / Kidney	<input type="checkbox"/>
Aorta	<input type="checkbox"/>
Pelvic	<input type="checkbox"/>
Transvaginal	<input type="checkbox"/>
OB (obstetrics) 1 st Trimester	<input type="checkbox"/>
OB (obstetrics) 2 nd and 3 rd Trimester	<input type="checkbox"/>
Testicular	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>
Other	

Physician Information

Patients with pacemakers, intracranial aneurysm clips or who may be pregnant are excluded from having an MRI.

Diagnosis and History / Special Remarks: _____
 Referring Physician: _____
 Phone: _____ Fax: _____
 Signature: _____ Date: _____

Important Instructions and Things to Know About Your Procedures.

- Please arrive 30 minutes prior to your scheduled appointment.
- Please bring previous MRIs, Cat Scans or X-rays of the area being scanned on your scheduled appointment.

MRI Prep: 1. We need to be notified if the patient has any implanted devices such as pacemakers, aneurysm clips, pumps or shrapnel.

CT Scan Prep: 1. All CT scans that require (IV) intravenous contrast (head, neck, chest, abdomen, pelvis) require the patient to have NO food or drink 4 hours prior to exam. The patient may take medications with a small amount of water **2.** Abdomen and pelvic scans require the patient to take an oral contrast. This can be picked up at our office at least one day prior to exam. Instructions will be given on when to drink the contrast. **3.** Diabetic patients and those who are age 60 or over are required to have a recent (no later than 60 days) BUN and Creatinine drawn before their exam.

Ultrasound Prep: 1. Abdomen, aorta, gallbladder and pancreas scans require that you DO NOT eat or drink after midnight prior to exam. **2.** OB scans - drink 32 oz of fluid sixty (60) minutes prior to the scan and DO NOT empty bladder. **3.** Pelvic scans require 32 oz of fluid sixty (60) minutes prior to exam and DO NOT empty bladder.

MRA	w	w/o
Brain / Head		<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>
Chest	<input type="checkbox"/>	
Aortic Arch	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	
Renal Artery	<input type="checkbox"/>	
Iliac Artery	<input type="checkbox"/>	
Lower Extremity	<input type="checkbox"/>	
Upper Extremity	<input type="checkbox"/>	
Other		