

Patient Name: _____ Appointment Date: _____ Appointment Time: _____

Referring Physician: _____ Physician Signature: _____

Exam(s): _____ Physician Office Phone: _____

Patient D.O.B.: _____ SSN: _____ Home Phone: _____ Cell Phone: _____

Signs/Symptoms/Diagnosis: _____

SPECIAL INSTRUCTIONS: _____

Latex Allergy: YES NO NPO: YES NO Call physician with report?

CONTRAST: Without With With & Without At Radiologist Discretion

MRI	HEAD	SPINE	ABDDOMEN	PELVIS	NECK	UPPER EXTREMITIES	LOWER EXTREMITIES
	<input type="checkbox"/> Brain <input type="checkbox"/> MRA/MRV <input type="checkbox"/> IACs <input type="checkbox"/> Orbits <input type="checkbox"/> Pituitary	<input type="checkbox"/> C-Spine <input type="checkbox"/> T-Spine <input type="checkbox"/> L-Spine	<input type="checkbox"/> MRCP <input type="checkbox"/> Liver <input type="checkbox"/> Kidney <input type="checkbox"/> MRA Renal	<input type="checkbox"/> Sacrum <input type="checkbox"/> Coccyx <input type="checkbox"/> Hips	<input type="checkbox"/> Soft Tissue <input type="checkbox"/> MRA Carotids	<input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT	<input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT

**** Please include films and/or reports of other studies that would allow correlation ****

ULTRASOUND	<input type="checkbox"/> Abdomen <input type="checkbox"/> Obstetric <input type="checkbox"/> Breast Ultrasound	<input type="checkbox"/> Aorta <input type="checkbox"/> Pelvis <input type="checkbox"/> Testicular <input type="checkbox"/> Renal	<input type="checkbox"/> Thyroid <input type="checkbox"/> RUQ <input type="checkbox"/> OTHER	<input type="checkbox"/> Venous r/o DVT Extremity, Specify: <input type="checkbox"/> Carotid <input type="checkbox"/> Echocardiogram
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CT	<input type="checkbox"/> HEAD <input type="checkbox"/> CHEST <input type="checkbox"/> ABDOMEN <input type="checkbox"/> PELVIS	<input type="checkbox"/> SPINE <input type="checkbox"/> C-Spine <input type="checkbox"/> T-Spine <input type="checkbox"/> L-Spine <input type="checkbox"/> Pelvis (Fx) <input type="checkbox"/> ST Neck	<input type="checkbox"/> CT ANGIOGRAPHY <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Aorta w/ runoffs <input type="checkbox"/> Head <input type="checkbox"/> Neck	<input type="checkbox"/> EXTREMITIES <i>(Specify Site)</i>	<input type="checkbox"/> OTHER <i>(Specify Type)</i>
	PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO Recent BUN/Creatinine/GFR: _____	Date of Labs: _____			

**** Please include films and/or reports of other studies that would allow correlation ****

GENERAL X-RAY	<input type="checkbox"/> C-Spine <input type="checkbox"/> T-Spine <input type="checkbox"/> L-Spine	<input type="checkbox"/> Chest PA/LAT <input type="checkbox"/> Abdomen <input type="checkbox"/> Abdominal Series Flat/Upright	<input type="checkbox"/> Hips <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> Upper Extremities <input type="checkbox"/> Lower Extremities	<input type="checkbox"/> IVP <input type="checkbox"/> HSG <input type="checkbox"/> OTHER
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FLUOROSCOPY	<input type="checkbox"/> Barium Swallow <input type="checkbox"/> Upper GI	<input type="checkbox"/> Barium Enema <input type="checkbox"/> Upper GI /Small Bowel	<input type="checkbox"/> OTHER <input type="checkbox"/> Small Bowel
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NUCLEAR MEDICINE	HEART <i>(Specify Type)</i> <input type="checkbox"/> Treadmill <input type="checkbox"/> Adenosine/Lexiscan <input type="checkbox"/> Dobutamine <input type="checkbox"/> MUGA <input type="checkbox"/> Viability PARATHYROID <i>(Include Bloodwork)</i> <input type="checkbox"/> PTH, Calcium	HEPATOBILLARY SCAN <input type="checkbox"/> Hida Only <input type="checkbox"/> Hida with CCK TUMOR LOCALIZATION <input type="checkbox"/> MIGB <input type="checkbox"/> Octreoscan <input type="checkbox"/> Sentinel Node <i>(Breast/Melanoma)</i>	LIVER/SPLEEN <input type="checkbox"/> Liver Scan <input type="checkbox"/> Hemangioma GI STUDIES <input type="checkbox"/> Meckel's <input type="checkbox"/> Gastric Empty <input type="checkbox"/> GI Bleed	BONE SCAN <input type="checkbox"/> Whole Body <input type="checkbox"/> 3 Phase <input type="checkbox"/> SPECT (Area) <input type="checkbox"/> Bone Marrow Scan LUNG STUDIES <input type="checkbox"/> VQ <input type="checkbox"/> Quantitative	THYROID <input type="checkbox"/> Uptake and Scan <i>(Include Bloodwork)</i> <input type="checkbox"/> I-131 Hyperthyroid Therapy OTHER <i>(Specify Type)</i>	INFECTIOUS SCANS <input type="checkbox"/> Indium WBC <input type="checkbox"/> Ceretec WBC <input type="checkbox"/> Gallium
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**** Please include films and/or reports of other studies that would allow correlation ****

WOMEN'S IMAGING	DIGITAL MAMMOGRAM <input type="checkbox"/> Screening <input type="checkbox"/> Diagnostic w/ Ultrasound indicated <input type="checkbox"/> Needle Localization <input type="checkbox"/> Breast Ultrasound
	BONE DENSITY <input type="checkbox"/> DEXA Scan



Fax to 469-713-8492, For appointment information, or to reschedule, call 817-255-1999.



EXAM PREPARATIONS

Bring this form to your appointment, and inform our radiology technologists of any allergies you may have or if you are pregnant or nursing. Please plan to arrive 30 minutes ahead of the scheduled exam time to register for the exam at Central Registration.

Computed Tomography (CT)

Come to the Radiology Department at least one day prior to your exam to receive oral contrast and instructions.

If you have a history of allergy to contrast media (X-ray dye), please contact your physician the day before the examination. Nursing mothers must stop breast feeding for 48 hours after study.

Head, Neck, Chest: Nothing by mouth 2 hours prior to study.

Abdominal, Pelvis: Nothing to eat or drink 4 hours prior to your examination. If you have had any barium studies within the last 3 days, your physician should prescribe a laxative.

Magnetic Resonance Imaging (MRI)

Inform us if you have a pacemaker, artificial heart valves, any metal objects in your body, are pregnant or nursing. Without contrast: No preparation is required. For abdominal MRI, do not eat or drink 4 hours before your exam.

Pelvic or Obstetric Ultrasound

This examination requires a full bladder. One hour before your appointment, empty your bladder and immediately drink 32 oz. of any liquid. Please do not empty your bladder until after your examination is completed. *No preparation is necessary for patients more than 16 weeks pregnant.*

Abdominal Ultrasound

Do not eat, drink, smoke or chew gum after midnight the night before your appointment.

Barium Enema

Must visit Radiology Department by noon, the day before your exam. Follow instructions on enema prep kit.

Breast Studies

Do not use deodorant, powder or lotion in the breast and underarm area. For your comfort, two-piece outfits are recommended. Please bring any previous mammogram films or call that office and have them sent to us at the North Hills Hospital, 4375 Booth Calloway Rd., North Richland Hills, TX 76180.

Dexa Scan/Bone Density - Located in Women's Imaging

No calcium supplements on the day of the scan. No barium contrast studies five days before the exam. Please do not wear clothing with metal or zippers.

Upper GI/Small Bowel Series

Please do not eat or drink after midnight until after your procedure is completed the following day.

IVP

1) Take 4 Dulcolax tablets (over the counter item available at your pharmacy) at 8 p.m. the day before your procedure. 2) Do not eat or drink after 8 p.m. except clear liquids. 3) Nothing to drink 2 hours before exam.

Nuclear Medicine

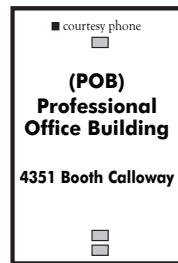
1) Bone Scan - You may eat and drink. Your first appointment is for the injection. You will return 3 hours later for the scan, which takes about 1 hour.
 2) Lung Scan - You will have to bring a chest X-ray with you that has been taken within 24 hours, or have one taken while you are here.
 3) HIDA - Do not eat or drink after midnight the night before or morning of the exam. Ask your doctor about taking medications.
 4) Thallium (Stress or Adenosine) - Do not eat or drink after midnight the night before or the morning of the exam. Ask your doctor about taking medications.
 5) Thyroid Uptake & Scan - Do not eat or drink after midnight the night before or the morning of the exam. You should be off all thyroid medications for this exam.



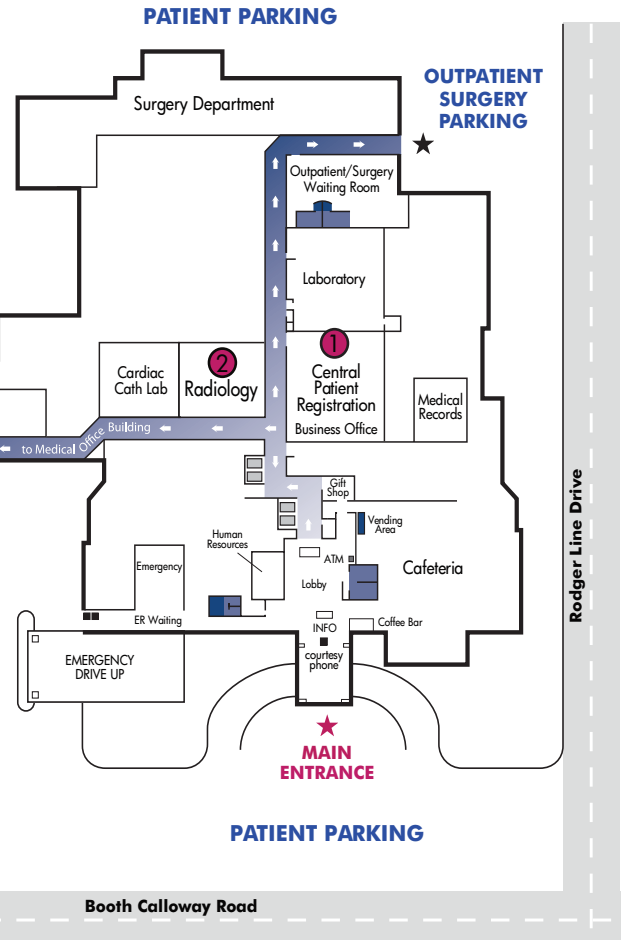
4401 Booth Calloway Road
 North Richland Hills, TX 76180
northhillshospital.com

- Hospital Entrances
- Elevators
- Restrooms
- Vending Machines
- ATM/Cash Machine
- Courtesy phone

PATIENT PARKING



PATIENT PARKING



For questions about your appointment, call scheduling at 817-255-1999.

For questions about the procedure or preparations, please call Radiology at 817-255-1855.