EMORY HEALTHCARE | **The frontline of care. The forefront of discovery.**

Preregistration Phone # 404-251-1239
For appointment please call 404-686-XRAY (9729)
Radiology Locations: https://bit.ly/4bZRScI
Fax: 404-778-3335

Medical Record Number:
Patient Name *(Last, First, MI)*:

Date of Birth: Weight: ◯Female ◯Male
Insurance Plan/FSC:
Member Insurance #:
Referral #: *Provide PCP to Specialist referral #.*

Required information to schedule
Attending MD Name:
NPI #*: **NPI needed for physicians*
Office Phone #: Fax:
Contact Requesting Physician @:
Office Contact: Phone #:
Patient's Phone (H/W/Cell):

ICD Codes: _____
Diagnosis/Indications: _____

Urgency: ◯Stat ◯Today ◯Routine, Requested Exam Date: _____
Scheduled Date: _____ Scheduled Time: _____ Location: _____
Additional Comments: _____

MRI

Implanted Metal? (i.e., Pacemaker) ◯YES ◯NO
Claustrophobic? ◯YES ◯NO
Needs Sedation ◯YES ◯NO

☐ Brain ☐ IAC/Temporal Bone
☐ Pituitary/Sella ☐ Orbits
☐ Neck/Face ☐ Brachial Plexus
☐ Temporomandibular Joint/TMJ
☐ Soft tissue / Neck area of interest: _____

◯***W/WO Contrast*** ◯***W/O Contrast***
☐Chest ☐ Abdomen ☐ Pelvis
(Default is without and with IV Contrast)
☐ C-Spine ☐ T-Spine ☐ L-Spine
◯***Contrast*** ◯***W/O Contrast*** ◯***W/WO Contrast***

Lower ext: ☐ Hip ☐ Knee ☐ Ankle ☐ Foot
☐ Leg ☐ Femur ☐ Pelvis ☐ Tibia Fibula

Upper ext: ☐ Shoulder ☐ Elbow ☐ Wrist
☐ Humerus ☐ Forearm
◯***Contrast*** ◯***W/O Contrast*** ◯***W/WO Contrast***

☐ Functional Mapping ☐ Perfusion
☐ Stealth ☐ Epilepsy
☐ Dementia/Alzheimers ☐ Chiari
☐ MS ☐ Chest Wall Mass
☐ Mediastium Mass ☐ Abdomen
☐ Enterography ☐ Elasography
☐ Liver Quantification ☐ Pelvis
☐ Prostate ☐ Rectal
☐ MSK Pelvis ☐ Sacrum/Coccyx

MR Angiography ***(Neuro)***
☐ MRA Brain ☐ MRA Neck ☐ MRV Brain
◯***W/O Contrast*** ◯***W/WO Contrast***

☐ MR Angiography ***(Body)***
☐ MRV
☐ Chest ☐ Abdomen ☐ Pelvis
☐ Extremities
Specify Body Part: _____
(Default is without and with IV Contrast)

☐ 3D-specific question to be answered: _____
MRI Additional Instructions: _____

COMPUTED TOMOGRAPHY - CT

☐ Facial Bones ◯ Contrast ◯ W/O Contrast
☐ Head ◯ Contrast ◯ W/O Contrast
☐ Orbits ◯ Contrast ◯ W/O Contrast
☐ Temporal Bone ◯ Contrast ◯ W/O Contrast
☐ Sinus ◯ Contrast ◯ W/O Contrast
☐ Soft Tissue Neck ◯ Contrast ◯ W/O Contrast
☐ Chest ◯ Contrast ◯ W/O Contrast
☐ Abdomen ◯ Contrast ◯ W/O Contrast
☐ Pelvis ◯ Contrast ◯ W/O Contrast
☐ CT Cardiac Calcium Score
☐ Coronary CTA
☐ Structural CTA
☐ Structural STA + Morph
☐Afib ☐Watchman
☐ CT Virtual Colonoscopy
☐ CT Urogram
☐ CT Angiography (CTA With Contrast)
☐ Head ☐ Neck ☐ Chest ☐ Abdomen
☐ Pelvis ☐ Lower extremities
☐ Other – Specify Site: _____
☐ 3D-Post Processing - Specific questions to be answered: _____

ROUTINE EXAMS (No Appointment Needed)

☐ Chest PA & Lateral ☐ Chest PA
☐ Rib Detail (◯RT ◯LT) ☐ Nasal Bones
☐ Spine (◯Cervical ◯Thoracic ◯Lumbar)
☐ KUB (IV) ☐ Flat & Upright ☐ Pelvis
☐ Acute Abdominal Series (CXR, 2V Abd)
☐ Extremities/joints (specify): _____
☐ Other: _____

GI TRACT / GU TRACT

☐ Upper GI Series
☐ Swallow..... ◯ Barium ◯ Gastrografin
☐ Enema..... ◯ Barium ◯ Gastrografin
☐ Modified Barium Swallow
☐ Small Bowel Series
☐ IV Urogram ☐ Cystogram Voiding
☐ Other: _____

BONE DENSITY

☐ Spine/Hip/Forearm
☐ Other: _____

ULTRASOUND

Non-OB Ultrasound

☐ Abdominal Complete ☐ With Doppler
☐ Abdominal Limited/RUQ ☐ With Doppler
☐ Retroperitoneum (kidneys and bladder)
☐ Aorta ☐ Retroperitoneum (kidneys and bladder)
☐ Head and Neck ☐ Soft Tissue
☐ Upper Extremity Non-Vas
◯RT ◯LT ◯BIL
☐ Lower Extremity Non-Vas
◯RT ◯LT ◯BIL
☐ Chest ☐ Upper back
☐ Upper back _____
☐ Abdominal ☐ Lower back
☐ Lower back
☐ Pelvis Transabdominal and Transvaginal
☐ With Doppler
☐ Thyroid
☐ Scrotal ☐ With Doppler
☐ Superficial (Specify)
◯ With Doppler ◯ W/O Doppler
☐ Other: _____

Vascular Ultrasound

☐ DVT (Venous)
◯Lower ◯Upper ◯Right ◯Left
☐ Arterial Eval
◯Lower ◯Upper ◯Right ◯Left
☐ Arterial Duplex with Grafft Surveillance
◯Lower ◯Upper ◯Right ◯Left
☐ Arterial Duplex complete w, ABI
◯Lower ◯Upper ◯Right ◯Left
☐ Arterial duplex pseudoaneurysm
☐ Arterial Eval Segmental Pressures
◯Lower ◯Upper ◯Right ◯Left
☐ Hemodialysis access ☐ Renal artery duples
☐ Carotid Bilateral ◯Right ◯Left
☐ Venous reflux
☐ Other: _____

Physician Signature: (MD, DO, NP, PA) **Date:** **Time:**

Click here for additional forms

Revision Date 04/2026