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

Emory Hospital Perry & Emory Hospital Warner Robins
Preregistration Phone # 404-251-1239
For appointment please call 404-686-XRAY (9729)
Fax: 478-542-7928

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***
☐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***

☐ Dementia/Alzheimers
☐ MS
☐ Liver Quantification
☐ MSK Pelvis
☐ Epilepsy
☐ Chiari
☐ Abdomen
☐ Pelvis
☐ Rectal Sacrum/
☐ Coccyx

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

☐ MR Angiography ***(Body)***
☐ MRV
☐ 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
☐ 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
☐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
☐ Renal artery duples
☐Carotid Bilateral ◯Right ◯Left
☐Venous reflux
☐Other:
_____

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

Click here for additional forms