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/4bZRScl

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 ❑ Gastrograffin
❑ Enema........... ❑ Barium ❑ Gastrograffin
❑ 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:** ______