REFERRAL FORM

17360 HWY 3 WEBSTER, TX 77598
PH: 281-338-5575 FAX: 281-554-8407

ORDER DATE: _____/_____/________

DATE OF BIRTH: _____/_____/________

PATIENT NAME: ______________________________ MALE_______ FEMALE_______

CELL: (_______) ________-__________ HOME: (_______) ________-__________ WORK: (_______) ________-__________

PRIMARY INSURANCE: ____________________ MEMBER ID:____________________ PH: (_______) ________-__________

SECONDARY INSURANCE: ____________________ MEMBER ID:____________________ PH: (_______) ________-__________

REF. PHYSICIAN: ____________________ PH: (_______) ________-__________ FAX: (_______) ________-__________

DIAGNOSIS: ______________________________ ICD-10: ____________________

MRI

☐ **HIGHFIELD** ☐ **OPEN**
- ☐ ABDOMEN (HF ONLY)
- ☐ BRAIN
  - ☐ IAC ☐ ORBITS ☐ PITUITARY
- ☐ CERVICAL ☐ LUMBAR ☐ THORACIC
- ☐ CHEST
- ☐ SOFT TISSUE PELVIS (HF ONLY)
- ☐ BONY PELVIS
- ☐ SACRUM/COCCYX
- ☐ EXTREMITY (NON-JOINT)
  - ☐ RT ☐ LT ☐ UPPER ☐ LOWER
  - ______________________________
- ☐ EXTREMITY JOINT
  - ☐ RT ☐ LT ☐ UPPER ☐ LOWER
  - ______________________________
- ☐ FOREFOOT ☐ RT ☐ LT
- ☐ HINDFOOT / ANKLE ☐ RT ☐ LT
- ☐ OTHER ____________________

CONTRAST

☐ WITHOUT ☐ WO/W

CT

☐ **3D RECONSTRUCTION**
- ☐ ABDOMEN ☐ PELVIS
- ☐ BRAIN
- ☐ SINUS
- ☐ CERVICAL ☐ LUMBAR ☐ THORACIC
- ☐ CHEST ☐ LOW DOSE ☐ HIGH-RES
- ☐ CALCIUM SCORE
- ☐ EXTREMITY ☐ UPPER ☐ LOWER
  - ☐ RT ☐ LT ____________________
- ☐ SOFT TISSUE ____________________
- ☐ FACIAL BONES ____________________
- ☐ ORBITS
- ☐ OTHER ____________________

IV CONTRAST

☐ WITH ☐ WITHOUT ☐ WO/W

ORAL CONTRAST

☐ WITHOUT ☐ WITH

ULTRASOUND

- ☐ ABDOMEN
  - ☐ COMPLETE
  - ☐ LIMITED ____________________
- ☐ ABDOMINAL AORTIC (AAA)
- ☐ ARTERIAL LWR W/ABI ☐ RT ☐ LT
- ☐ ARTERIAL UPPER EXT ☐ RT ☐ LT
- ☐ ARTERIAL LOWER EXT ☐ RT ☐ LT
- ☐ VENOUS UPPER EXT ☐ RT ☐ LT
- ☐ VENOUS LOWER EXT ☐ RT ☐ LT
- ☐ CAROTID
- ☐ OBSTETRIC 1ST TRIMESTER
- ☐ PELVIC TRANSVAGINAL
- ☐ PELVIC TRANSABDOMINAL
- ☐ RENAL COMPLETE
- ☐ RENAL DOPPLER
- ☐ SCROTUM W/DOPPLER
- ☐ THYROID
- ☐ SOFT TISSUE
- ______________________________
- ☐ OTHER ____________________
- ______________________________

CT ARTHROGRAM

☐ RT ☐ LT ____________________

MR ARTHROGRAM

☐ RT ☐ LT ____________________

MRA

- ☐ BRAIN
- ☐ CAROTID
- ☐ CHOLANGIOGRAM (MRCP)
- ☐ MRV____________________
- ☐ OTHER
- ______________________________

CTA

- ☐ ABDOMEN
- ☐ AORTA ____________________
- ☐ CAROTID
- ☐ CHEST PE
- ☐ HEAD
- ☐ NECK
- ☐ PELVIC
- ☐ W/ RUNOFF
- ☐ OTHER ____________________
- ______________________________

IV CONTRAST ☐ WITH ☐ WO/W

PAIN MANAGEMENT / ESI

____

____

____

____

X-RAY

____

____

____

____

____

PHYSICIAN SIGNATURE

X ______________________________

SPECIAL INSTRUCTIONS

☐ **STAT** *NOTE: ORDERS RECEIVED AFTER 4PM MAY BE PROCESSED THE NEXT BUSINESS DAY.*

☐ CLAUSTROPHOBIC

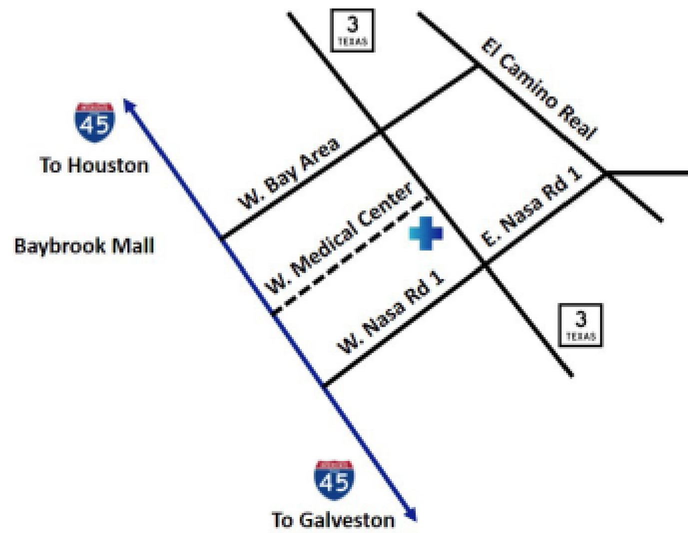
☐ PATIENT TO TAKE CD

☐ OTHER ____________________

____

NOTE: Weight limit is 350 lbs. for Highfield MRI, 400 lbs. for Open MRI and 500 lbs. for CT.

17360 HWY 3 WEBSTER, TX 77598
PH: 281-338-5575 FAX: 281-554-8407



We are located on the corner of Highway 3 and Medical Center Blvd, next door to the gas station.