

**WFUBMC
IMAGING
CONSULTATION
REQUEST FORM**



Patient Label

Patient Name _____ Date of Birth ____ / ____ / ____
 (Last) (First) MI
 Insurance (Primary) _____ Group # / Plan # _____ Phone # _____
 Blood Work Results (if needed): BUN _____ Creatinine _____ Prior Authorization # (if applicable/available) _____
 ICD 9 Code _____ Signs/Symptoms _____
 Physician's Name (Printed) _____ Physician's Signature _____
 Physician's Phone # _____ Fax # _____ Pager # _____

MAGNETIC RESONANCE IMAGING (MRI)	COMPUTERIZED TOMOGRAPHY (CT)
MRI Contrast <input type="checkbox"/> w/o <input type="checkbox"/> w/o & w <input type="checkbox"/> Radiologist discretion Sedation Needed Y N <input type="checkbox"/> Brain <input type="checkbox"/> Shoulder <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Elbow <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> C-Spine <input type="checkbox"/> Wrist <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> T-Spine <input type="checkbox"/> Hip <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> L-Spine <input type="checkbox"/> Knee <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Abdomen (Specify) _____ <input type="checkbox"/> Ankle <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Pelvis (Specify) _____ <input type="checkbox"/> Foot <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Breast <input type="checkbox"/> B <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Cardiac (specify) _____ MRA: <input type="checkbox"/> Brain _____ <input type="checkbox"/> Carotids _____ <input type="checkbox"/> Abdomen/Pelvis _____ <input type="checkbox"/> Extremity (Run-off) _____ <input type="checkbox"/> Other (Specify) _____	Oral Contrast <input type="checkbox"/> without <input type="checkbox"/> with IV Contrast <input type="checkbox"/> without <input type="checkbox"/> with <input type="checkbox"/> without and with <input type="checkbox"/> Radiologist discretion <input type="checkbox"/> Head <input type="checkbox"/> Abdomen CTA: (requires contrast) <input type="checkbox"/> Facial <input type="checkbox"/> Abdomen/Pelvis <input type="checkbox"/> Head CTA <input type="checkbox"/> Orbits <input type="checkbox"/> Stone Study <input type="checkbox"/> Head/Neck CTA <input type="checkbox"/> Sinuses Full <input type="checkbox"/> Pelvis <input type="checkbox"/> Neck CTA <input type="checkbox"/> Sinuses Mini <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Chest CTA <input type="checkbox"/> Temporal Bones _____ <input type="checkbox"/> Chest/Abdomen/Pelvis <input type="checkbox"/> Neck (soft tissue) <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Abdomen CTA <input type="checkbox"/> Neck/Chest/ Abdomen <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Abdomen/Pelvis CTA <input type="checkbox"/> Neck/Chest/ Abdomen/Pelvis <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Abdomen/Pelvis/LE CTA <input type="checkbox"/> Chest <input type="checkbox"/> Upper Extremity R / L <input type="checkbox"/> Upper Extremity R / L <input type="checkbox"/> Chest for Pulmonary Embolus <input type="checkbox"/> Lower Extremity R / L <input type="checkbox"/> Lower Extremity R / L <input type="checkbox"/> Chest/Abdomen/Pelvis <input type="checkbox"/> Cardiac CTA
NUCLEAR MEDICINE / PET	ABDOMINAL ULTRASOUND
Nuclear Medicine <input type="checkbox"/> Bone Scan Whole Body <input type="checkbox"/> Parathyroid <input type="checkbox"/> Bone Scan 3 Phase <input type="checkbox"/> Thyroid Scan area _____ <input type="checkbox"/> Thyroid Uptake <input type="checkbox"/> Brain SPECT <input type="checkbox"/> Thyroid Therapy <input type="checkbox"/> Biliary Patency <input type="checkbox"/> Thyroid Uptake/Therapy <input type="checkbox"/> with ejection fraction <input type="checkbox"/> Thyroid Total Body Scan <input type="checkbox"/> Gastric Emptying <input type="checkbox"/> Thyroid Ablation Therapy <input type="checkbox"/> Solid OR <input type="checkbox"/> Liquid <input type="checkbox"/> Renal Scan DMSA <input type="checkbox"/> Lung Perfusion and Ventilation <input type="checkbox"/> Renogram <input type="checkbox"/> Myocardial Perfusion Rest&Stress <input type="checkbox"/> w OR <input type="checkbox"/> w/o lasix <input type="checkbox"/> MUGA w/ ejection fraction <input type="checkbox"/> Octreoscan <input type="checkbox"/> Other _____ <input type="checkbox"/> Indium WBC Scan	<input type="checkbox"/> Complete Abdomen <input type="checkbox"/> Thyroid <input type="checkbox"/> RUQ <input type="checkbox"/> Neonatal Head <input type="checkbox"/> Aorta (includes Doppler) <input type="checkbox"/> Renal (kidneys and bladder) <input type="checkbox"/> Transabdominal Pelvis Only <input type="checkbox"/> Vasc. Abd (TIPS, Hepatic Doppler, <input type="checkbox"/> Endovaginal (includes limited Renal Doppler - Adult Only) * <input type="checkbox"/> transabdominal views) <input type="checkbox"/> Renal Transplant <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Scrotal (includes doppler) <input type="checkbox"/> Pancreas Transplant <input type="checkbox"/> Lower Ext Venous Doppler <input type="checkbox"/> B <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Pylorus (peds only) <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Infant Hips (Peds only) <input type="checkbox"/> with stress <input type="checkbox"/> without stress
PET-CT <input type="checkbox"/> Diagnosis <input type="checkbox"/> Staging <input type="checkbox"/> Response	MAMMOGRAPHY
<input type="checkbox"/> Brain (Alzheimer's, Dementia, Seizure) <input type="checkbox"/> Cervical <input type="checkbox"/> Lymphoma <input type="checkbox"/> Colorectal <input type="checkbox"/> Melanoma <input type="checkbox"/> Esophageal <input type="checkbox"/> Myocardial Viability <input type="checkbox"/> Head & Neck <input type="checkbox"/> Thyroid <input type="checkbox"/> Lung <input type="checkbox"/> Other _____ <input type="checkbox"/> Single Pulmonary Nodule	<input type="checkbox"/> Screening Mammogram <input type="checkbox"/> Diagnostic Mammogram <input type="checkbox"/> Bilateral <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Breast Ultrasound <input type="checkbox"/> Bilateral <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Breast Ultrasound Needle Biopsy <input type="checkbox"/> Breast Stereo Needle Biopsy
DIAGNOSTIC X-RAY	
<input type="checkbox"/> Abdomen (KUB) <input type="checkbox"/> Orbits <input type="checkbox"/> Abdomen Complete (includes obliqs before/after CT) <input type="checkbox"/> Osseous Survey <input type="checkbox"/> Acute Abdomen Series (Flat, upright, 1 view chest) <input type="checkbox"/> Pelvis (AP) <input type="checkbox"/> Chest (PA & Lat) <input type="checkbox"/> Ribs Cervical Spine: <input type="checkbox"/> Sacrum/coccyx (AP/Lat) <input type="checkbox"/> (AP/Lat) Limited <input type="checkbox"/> Scoliosis (AP/Lat) <input type="checkbox"/> AP/Lat/Obl complete <input type="checkbox"/> Shunt Series (AP/Lat Skull, AP/Lat Chest, <input type="checkbox"/> AP/Lat/Flexion/Extension (4 views) AP/Lat Abdomen) <input type="checkbox"/> Hip(s) <input type="checkbox"/> B <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> SI Joints Lumbar Spine: <input type="checkbox"/> Skull <input type="checkbox"/> (AP/Lat) Limited <input type="checkbox"/> Soft Tissue Neck (AP/Lat) <input type="checkbox"/> AP/Lat/Obl Complete <input type="checkbox"/> Sternum <input type="checkbox"/> AP/Lat/Flexion/Extension (4 views) <input type="checkbox"/> Thoracic Spine	Extremities: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="checkbox"/> Ankle <input type="checkbox"/> Calcaneus <input type="checkbox"/> Clavicle <input type="checkbox"/> Elbow <input type="checkbox"/> Femur <input type="checkbox"/> Finger(s) <input type="checkbox"/> Foot <input type="checkbox"/> Forearm <input type="checkbox"/> Hand <input type="checkbox"/> Humerus <input type="checkbox"/> Knee <input type="checkbox"/> Scapula <input type="checkbox"/> Shoulder <input type="checkbox"/> Tib/Fib <input type="checkbox"/> Toe(s) <input type="checkbox"/> Wrist <input type="checkbox"/> Other (Specify) _____
FLUOROSCOPY PROCEDURES	
<input type="checkbox"/> Arthrogram (Specify) _____ <input type="checkbox"/> Myelogram <input type="checkbox"/> Barium Enema <input type="checkbox"/> with Air <input type="checkbox"/> without Air <input type="checkbox"/> Cervical <input type="checkbox"/> Upper GI <input type="checkbox"/> Voiding Cysto Urethrogram <input type="checkbox"/> Thoracic <input type="checkbox"/> Upper GI with Small Bowel <input type="checkbox"/> Cystogram <input type="checkbox"/> Lumbar <input type="checkbox"/> Small Bowel <input type="checkbox"/> IVP <input type="checkbox"/> Epidural Steroid Injection <input type="checkbox"/> Enteroclysis <input type="checkbox"/> Loopogram <input type="checkbox"/> Facet Injection <input type="checkbox"/> T-Tube Cholangiogram <input type="checkbox"/> Defocography	
INTERVENTIONAL RADIOLOGY (including Angiography, CT and US Guided Procedures) (336) 716-4747	

**All information MUST be filled in completely before your request can be processed.
 Department Phone Numbers, Patient Preparations and Maps are on the reverse side.**

Patient Preparation / Special Instructions

If there is any chance the patient is pregnant, please consult the Radiologist

MRI

Prep Instructions: MRI cannot be performed on patients with cardiac pacemakers, some cardiac valves and stents, otologic implants, neurostimulators and some aneurysm clips in the brain or if there is a possibility of metal fragments in the eye or other body parts. Please bring any information pertaining to stents or implants that you may have to the appointment.

If you have ever had a serious reaction to **any type of contrast material**, please notify your physician prior to your appointment.

****Bloodwork (must be within 30 days) - Creatinine levels are required** if the patient is having an MRI with contrast and meets **ANY** of the following conditions:
Has kidney disease, had had kidney surgery or is on dialysis

Nuclear Medicine / PET

Nuclear Medicine Instructions:

Biliary Patency and Gastric emptying - nothing to eat past midnight
Myocardial Perfusion - nothing to eat past midnight, no caffeine for 24 hours prior to exam
Thyroid Uptake and Therapy - nothing to eat past midnight

PET Instructions:

Low carbohydrate diet 48 hours prior to scan
Nothing to eat or drink 4 hours prior to scan

Computerized Tomography (CT)

The following studies **must** be done in the Main Radiology Department, 1st floor Reynolds Tower: Brain Lab Studies, Cardiac Studies, Coronary Calcium, Heart and Coronary Studies, Perfusion, Scanogram, Stealth Studies and **ALL** patients who require pre-medication.

You may eat a normal diet and take any daily medications. You may be instructed to drink a liquid and wait before the examination begins. Your wait time will depend on the type of exam your physician has ordered.

Abdominal Ultrasound

Abdomen, Aorta, RUQ, Vascular Abdomen, Pancreas Transplant - nothing to eat or drink for a minimum of 6 hours prior to appointment

Renal Doppler - nothing to eat or drink for a minimum of 8 hours prior to study

Bladder (PVR), Transabdominal Pelvis - drink 32 ounces of a liquid of your choice 45 minutes prior to exam. Hold fluid in the bladder until the exam is finished.

Mammography

Patient Instructions/Suggestions:

If you wear deodorant, you will be asked to wash it off before mammogram.

Two piece clothing will be more convenient for you.

Scheduling your mammogram for the week after your menstrual period may help reduce breast tenderness.

Please arrive 15 minutes before your scheduled appointment time.

Note: The purple level in parking lot C or the M level has a walkway to the 4th floor of the Cancer Center

Fluoroscopy (GI/GU Studies)

Esophagram (Barium Swallow): No Prep

Upper GI and/or Small Bowel:

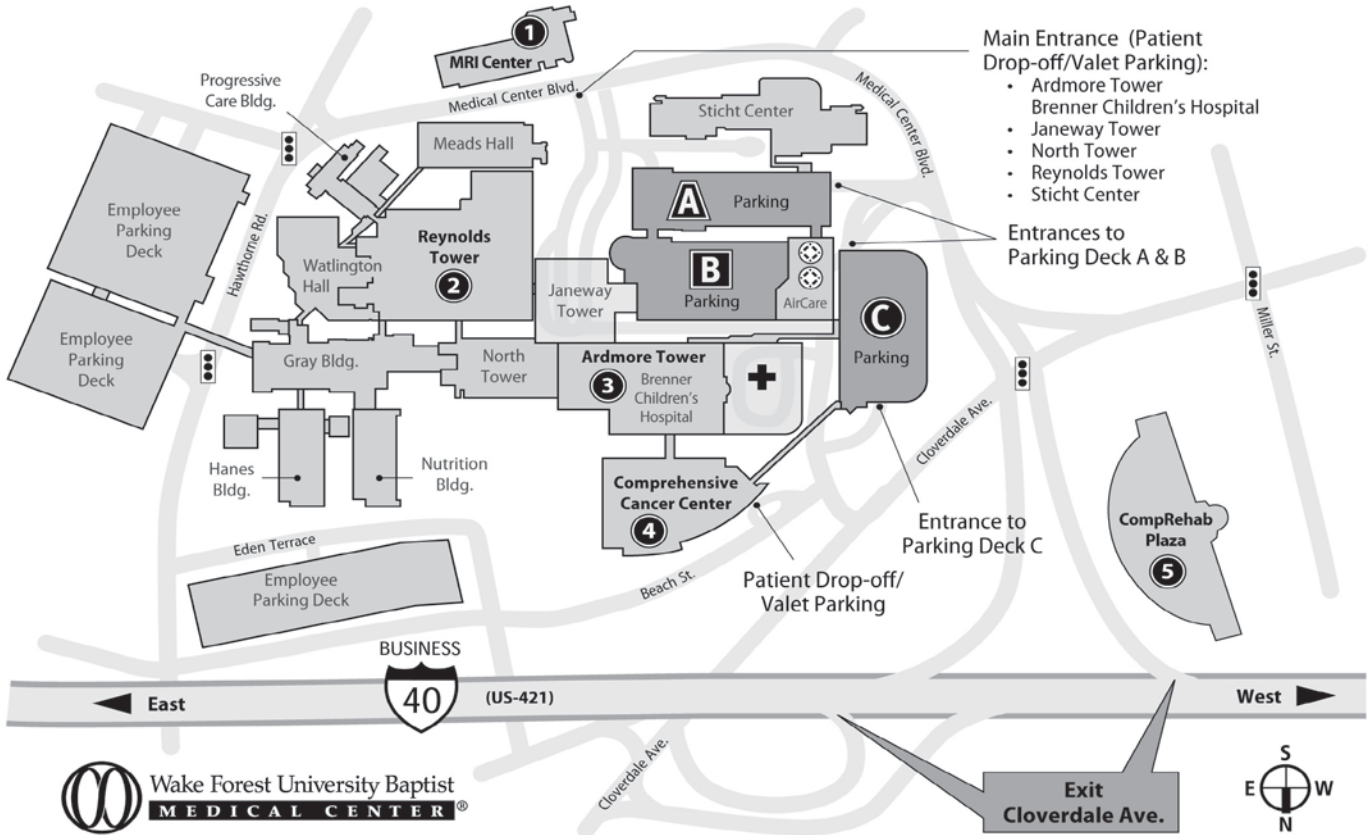
Nothing to eat or drink after midnight, including gum and cigarettes
If patient has had a barium study within 4 days prior to Upper GI Study, Barium Enema prep is required

Barium Enema / Colostomy Barium Enema:

24 hour clear liquid diet
8 oz. glass of water every hour from 9:00am - 9:00 pm
At 12:00 noon the day before exam, drink a 10 oz. bottle of Magnesium Citrate
At 4:00pm the day before exam, drink 2 ozs of Castor Oil with a glass of juice
Nothing to eat or drink after midnight

Intravenous Pyelogram (IVP):

Clear liquid diet the day before exam
At 12:00 noon the day before exam, drink a 10 oz bottle of Magnesium Citrate
At 4:00pm, take 4 Dulcolax tablets by mouth with a glass of water
Drink 8 oz glass of water or other liquid every hour from 12:00 noon until midnight (bedtime)
Nothing to eat or drink after midnight



Department	Phone Number	Fax Number	Hours of Operation	Location	Map Reference
Magnetic Resonance Imaging (Mon - Fri)	(336) 716-3291	(336) 716-7432	7:00 am - 11:00 pm	1st Floor MRI Center	1
Magnetic Resonance Imaging (Sat - Sun)	(336) 716-3291	(336) 716-7432	7:00 am - 7:00 pm	1st Floor MRI Center	1
PET Center	(336) 716-5600	(336) 716-6108	7:00 am - 5:00 pm	Ground Floor MRI Center	1
Main Radiology	(336) 716-3560	(336) 716-0770	7:30 am - 11:00 pm	1st Floor Reynolds Tower	2
CT Scanning (Main Department)	(336) 716-1920	(336) 716-0770	7:30 am - 5:00 pm	1st Floor Reynolds Tower	2
Pediatric Radiology	(336) 716-3560	(336) 713-4602	5:00 pm - 11:00 pm	1st Floor Reynolds Tower	2
Cardiac Magnetic Resonance Imaging	(336) 716-8663	(336) 716-8683	7:00 am - 6:00 pm	1st Floor Reynolds Tower	2
Abdominal Ultrasound (Adult)	(336) 716-0460	(336) 716-0770	8:00 am - 4:00 pm	1st Floor Reynolds Tower	2
Interventional Radiology	(336) 713-4747	(336) 713-5145	7:30 am - 4:30 pm	1st Floor Reynolds Tower / South Bldg	2
Nuclear Medicine	(336) 716-3520	(336) 716-6108	8:00 am - 5:00 pm	Main Floor Reynolds Tower	2
Abdominal Ultrasound (Pediatric)	(336) 713-4600	(336) 713-4602	8:15 am - 4:45 pm	7th Floor Ardmore Tower Brenners	3
Pediatric Radiology	(336) 713-4600	(336) 713-4602	7:30 am - 4:30 pm	7th Floor Ardmore Tower Brenners	3
Comprehensive Cancer Center Radiology	(336) 713-3700	(336) 713-6747	7:30 am - 5:00 pm	4th Floor Comprehensive Cancer Center	4
Mammography	(336) 713-6500	(336) 713-6688	7:30 am - 5:00 pm	4th Floor Comprehensive Cancer Center	4
Abdominal Ultrasound (Adult)	(336) 716-0460	(336) 713-6688	8:00 am - 4:00 pm	4th Floor Comprehensive Cancer Center	4
Com Rehab Radiology	(336) 716-8200	(336) 716-8069	8:00 am - 4:30 pm	131 Miller Street	5
Urology Clinic Radiology	(336) 716-8273	(336) 716-8171	8:00 am - 5:00 pm	140 Charlois Blvd., Winston-Salem	