IMAGING CENTER Of Louisiana

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Baton Rouge, LA 70809
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APPOINTMENT

DATE:

TIME:

If you must reschedule or cancel your appointment, please give at least 24 hours notice.

Date of Referral: _____

Patient Name: _____
First M.I. Last

Chief Complaint(s) and Brief History: _____

☐ MRI ☐ MRA ☐ CT ☐ X-RAY — WITH CONTRAST ☐ YES ☐ NO

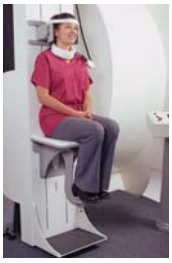
UPRIGHT/WEIGHT-BEARING

Brain

- ☐ Routine
- ☐ TMJ
- ☐ Posteria Fossa
- ☐ Sinuses
- ☐ IAC's
- ☐ Pituitary
- ☐ Orbits

MRA

- ☐ Circle of Willis
- ☐ Carotid Arteries



Spine

- ☐ Cervical - specify below
- ☐ Thoracic
- ☐ Lumbosacral - specify below

Lower Joints

- ☐ Hip ☐ L ☐ R
- ☐ Knee ☐ L ☐ R
- ☐ Ankle ☐ L ☐ R

Misc.

- ☐ Shoulder ☐ L ☐ R
- ☐ Elbow ☐ L ☐ R
- ☐ Wrist ☐ L ☐ R
- ☐ Prostate

Other: _____

Perform Recumbent Scan for Comparison? ☐ Yes ☐ No

RECUMBENT ONLY

- ☐ Abdomen
- ☐ Pelvis
- ☐ Prostate

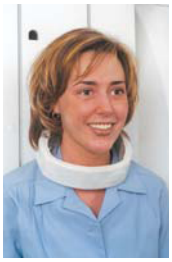
☐ Brain Specify _____

☐ Spine Specify _____

☐ Joints Specify _____

☐ Other Specify _____

CERVICAL



☐ Neutral Upright

☐ Flexion Upright

☐ Extension Upright

☐ Lateral Bending Upright

☐ L ☐ R

Perform Recumbent Scan for Comparison? ☐ Yes ☐ No

LUMBOSACRAL

☐ Neutral Upright

☐ Flexion Upright

☐ Extension Upright

☐ Lateral Bending Upright

☐ L ☐ R

Perform Recumbent Scan for Comparison? ☐ Yes ☐ No

Special Instructions or Comments: _____

Physician's Name: _____ Phone: _____ Physician's Signature: _____