** THIS FORM IS REQUIRED WHEN YOU CHECK IN FOR YOUR APPOINTMENT **

For all appointments, please arrive 20 minutes prior to exam

RADIOLOGY

❑ Upper GI or Small Bowel

- Do not eat or drink anything 8 hours before the procedure.
- Drink plenty of fluids after the procedure.

❑ Colon (Barium Enema)

- At noon the day before the procedure, have clear soup with crackers, apple or grape juice and gelatin for lunch. No dairy products until the procedure is completed.
- Between 1 p.m. - 2 p.m. drink 12-16 ounces of water.
- At 3 p.m. drink 10 ounces of cold *Magnesium Citrate**.
- At 4 p.m. take 2 *Dulcolax** tablets.
- At 5 p.m. you may have bouillon or gelatin, and black coffee, tea or juice.
- Between 6 p.m. and 7 p.m. drink 12-16 ounces of water.
- Do not eat breakfast the day of the procedure. However, you may drink black coffee, tea or water.

❑ IVP

❗ All patients that are diabetic and take Glucophage, Glucovance or Avandamet must discontinue these medications until 48 hours after the procedure.

- If you have suspected or known allergies to iodinated contrast media, inform your physician so arrangements can be made for pre-medication.
- If you take prescribed medications, follow the directions. Do not skip a dose.
- Take 4 Dulcolax* tablets between 1 p.m. and 2 p.m. the day before the procedure.
- Drink 8 ounces of water every hour between 2 p.m. and bedtime. Eat a light evening meal.
- Clear liquids should be continued until the time of the procedure.

**** Magnesium Citrate and Dulocolax are items that can be purchased at your local pharmacy.***

ULTRASOUND (SONOGRAM)

❑ Abdomen, Aorta, Gallbladder, or Pancreas

- Do not eat or drink anything 8 hours prior to the procedure.

❑ Pelvis or Pregnancy

- Drink 32 ounces of water 45 to 60 minutes prior to the procedure.
- Do not empty bladder until the procedure has been completed.

❑ Prostate or Transrectal

- 1½ hours prior to the procedure administer a Fleet Ready-to-Use-Enema which may be purchased at your local pharmacy.

CT SCAN

❗ All patients that are diabetic and take Glucophage, Glucovance or Avandamet must discontinue these medications until 48 hours after the procedure.

❗ If you have suspected or known allergies to iodinated contrast media, inform your physician so arrangements can be made for pre-medication. If you take prescribed medications, follow the directions. Do not skip a dose.

❑ Chest CT Scan

- If your most recent chest x-ray was performed at another facility, please bring that exam to your appointment.

❑ Pelvis CT Scan

- You will need to drink oral contrast media for this procedure. Contrast is provided by the Radiology department, and must be picked up the day before the procedure.

NUCLEAR MEDICINE

❑ Bone Scan (this is a two part study)

- For this procedure you will receive an injection and will be required to return 3 hours later.
- After the injection, please drink at least 64 ounces of water.
- Return to Radiology at the indicated time. The scan will take 1 hour.

❑ Gastric Emptying or Hepatobiliary/GBEF (Kinevac)

- Nothing to eat or drink after midnight.
- You will be informed if you need to return for an additional scan.
- An Ultrasound of the gallbladder may be required prior to gallbladder ejection (GBEF) study.

❑ Renal Scan (this may be a two day study)

- Drink 64 ounces of water prior to scan and empty bladder as needed.
- Consult with your physician on your medications. You may be instructed to stop your blood pressure or other medications for 48 hours prior to the procedure.

❑ Thyroid uptake and scan (this is a two part study)

- Do not eat or drink after midnight prior to the study.
- Thyroid exams require you to take a pill and return in 6 hours. It may be necessary for you to return the next day for an additional scan.

❑ Indium and Prostascint (multiple day exams)

- A bowel prep is required for these exams. Follow the IVP preparation.
- These procedures will take several days with scan times of 2 or more hours each day.

USMD Hospital at Arlington

801 West Interstate 20 Arlington, TX 76017

Scheduling: 817.472.3550
Fax: 817.472.3555

Radiology Requisition

Patient Name

Date Of Birth | Social Security #

Insurance

Home Phone # | Alternate Phone #

Referring Physician Name

Physician Signature

APPOINTMENT DATE/TIME

Reason for exam / ICD9CM code(s)

If precertification is on file, give authorization number

Attach a copy of your office face sheet, patient insurance card(s) front and back, and a copy of the patient's drivers license.
(These documents are mandatory for registration).

RADIOLOGY

- ❑ Chest
- ❑ Ribs
- ❑ Abdominal Series *(2 views)*
- ❑ Extremities
  - Left ❑
  - Right ❑
- ❑ Hip
  - Left ❑
  - Right ❑
- ❑ KUB
- ❑ Pelvis
- ❑ Spine
  - Cervical ❑
  - Thoracic ❑
  - Lumbar ❑
    - Standing ❑
    - Flex/Ext ❑

Other: _____

FLUOROSCOPY

- ❑ Esophagus*
- ❑ Upper GI*
- ❑ Small Bowel*
- ❑ Barium Enema*
- ❑ Cystogram
  - Static ❑
  - Voiding ❑
- ❑ Myelogram *(Post CT included)*
  - Cervical ❑
  - Thoracic ❑
  - Lumbar ❑
- ❑ IVP
- ❑ IVP/CT
- ❑ HSG

Other: _____

CT

- ❑ Brain
- ❑ IAC / Mastoid
- ❑ Orbits
- ❑ Sinuses
- ❑ Soft Tissue Neck
- ❑ Chest
- ❑ Abdomen*
- ❑ Extremity
  - Left ❑
  - Right ❑
- ❑ Pelvis*
- ❑ Spine
  - Cervical ❑
  - Thoracic ❑
  - Lumbar ❑

Other: _____

IV CONTRAST

❑Yes ❑No

ORAL CONTRAST

❑Yes ❑No

MAMMOGRAPHY

- ❑ Screening
- ❑ Diagnostic
  - Left ❑
  - Right ❑
- ❑ Cyst Aspiration
- ❑ Needle Localization
- ❑ Stereotactic Biopsy

Surgeon preference: _____

- ❑ Additional Views
  - Left ❑
  - Right ❑

Other: _____

ULTRASOUND

- ❑ Thyroid
- ❑ Thyroid Biopsy
- ❑ Breast
  - Left ❑
  - Right ❑
- ❑ Breast Biopsy
  - Left ❑
  - Right ❑
- ❑ Abdomen*
  - Complete* ❑
  - Limited* ❑
    - Area: _____
- ❑ Pelvis*
- ❑ Pregnancy / OB*
- ❑ Prostate*
- ❑ Scrotum / Testicle
- ❑ Biopsy: _____

Other: _____

DOPPLER

- ❑ Carotid
- ❑ Venous Extremity
  - Upper ❑
  - Lower ❑
- ❑ Graft Survey

Other: _____

NUCLEAR MEDICINE

- ❑ Brain Scan
- ❑ H. Pylori Breath test
- ❑ Parathyroid Scan
- ❑ Thyroid uptake & scan
- ❑ Breast Tumor
- ❑ Liver & Spleen
- ❑ Renal scan
  - Hypertension ❑
  - Flow function ❑
  - Lasix washout ❑
- ❑ Hemangioma
- ❑ Gastric Emptying*
- ❑ Bone scan
  - Whole ❑
  - 3 Phase ❑
- ❑ Hepatobiliary/GBEF*
- ❑ Indium WBC scan*
- ❑ Prostascint
  - SPECT ❑
  - Whole Body ❑
  - Limited Area ❑

_____

- CT (for fusion) ❑
- MRI (for fusion) ❑

Other: _____

MRI

- ❑ Brain
- ❑ Pituitary
- ❑ Orbit / Face
- ❑ IAC
- ❑ Neck
- ❑ Chest
- ❑ Abdomen
- ❑ Extremity
  - Left ❑
  - Right ❑
- ❑ Pelvis
- ❑ Spine
  - Cervical ❑
  - Thoracic ❑
  - Lumbar ❑

Other: _____

IV CONTRAST

❑Yes ❑No

MRA

- ❑ Head
- ❑ Neck

Other: _____

COMMENTS

❑ Radiologist is authorized to order additional exams or IV contrast, if needed.

Patient Label

* Procedure requires a preparation.
See exam instructions on back of form.