

Patient Name: _____ Appointment Date: _____ Appointment Time: _____

Referring Physician: _____ Physician Signature: _____

Exam(s): _____ Physician Office Phone: _____

Patient D.O.B.: _____ SSN: _____ Home Phone: _____ Cell Phone: _____

Signs/Symptoms/Diagnosis: _____

SPECIAL INSTRUCTIONS: _____

Latex Allergy: YES NO NPO: YES NO

CONTRAST: Without With With & Without At Radiologist Discretion

MRI	HEAD	SPINE	ABDDOMEN	PELVIS	NECK	UPPER EXTREMITIES	LOWER EXTREMITIES
	<input type="checkbox"/> Brain	<input type="checkbox"/> C-Spine	<input type="checkbox"/> MRCP	<input type="checkbox"/> Sacrum	<input type="checkbox"/> Soft Tissue	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Knee
	<input type="checkbox"/> MRA/MRV	<input type="checkbox"/> T-Spine	<input type="checkbox"/> Liver	<input type="checkbox"/> Coccyx	<input type="checkbox"/> MRA Carotids	<input type="checkbox"/> Elbow	<input type="checkbox"/> Ankle
	<input type="checkbox"/> IACs	<input type="checkbox"/> L-Spine	<input type="checkbox"/> Kidney	<input type="checkbox"/> Hips		<input type="checkbox"/> Wrist	<input type="checkbox"/> Foot
	<input type="checkbox"/> Orbits		<input type="checkbox"/> MRA Renal			<input type="checkbox"/> Hand	<input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT
	<input type="checkbox"/> Pituitary					<input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT	

**** Please include films and/or reports of other studies that would allow correlation ****

ULTRASOUND	Abdomen	Aorta	Thyroid	Venous r/o DVT Extremity, Specify:
	<input type="checkbox"/> Obstetric	<input type="checkbox"/> Pelvis	<input type="checkbox"/> RUQ	<input type="checkbox"/> Carotid
	<input type="checkbox"/> Breast Ultrasound	<input type="checkbox"/> Testicular	<input type="checkbox"/> OTHER	<input type="checkbox"/> Echocardiogram
		<input type="checkbox"/> Renal		

CT	HEAD	CHEST	ABDOMEN	SPINE	CT ANGIOGRAPHY	EXTREMITIES	OTHER
			<input type="checkbox"/> PELVIS	<input type="checkbox"/> C-Spine	<input type="checkbox"/> Chest	(Specify Site)	(Specify Type)
				<input type="checkbox"/> T-Spine	<input type="checkbox"/> Abdomen		
				<input type="checkbox"/> Pelvis (Fx)	<input type="checkbox"/> Pelvis		
				<input type="checkbox"/> ST Neck	<input type="checkbox"/> Aorta w/ runoffs		
					<input type="checkbox"/> Head <input type="checkbox"/> Neck		

PREGNANT YES NO

Recent BUN/Creatinine/GFR: _____ Date of Labs: _____

**** Please include films and/or reports of other studies that would allow correlation ****

GENERAL X-RAY	C-Spine	Chest PA/LAT	Hips	IVP
	<input type="checkbox"/> T-Spine	<input type="checkbox"/> Abdomen	<input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT	<input type="checkbox"/> HSG
	<input type="checkbox"/> L-Spine	<input type="checkbox"/> Abdominal Series	<input type="checkbox"/> Upper Extremities	<input type="checkbox"/> OTHER
		Flat/Upright	<input type="checkbox"/> Lower Extremities	

FLUOROSCOPY	Barium Swallow	Barium Enema	OTHER
	<input type="checkbox"/> Upper GI	<input type="checkbox"/> Upper GI /Small Bowel	<input type="checkbox"/> Small Bowel

NUCLEAR MEDICINE	HEART (Specify Type)	HEPATOBILLARY SCAN	LIVER/SPLEEN	BONE SCAN	THYROID	INFECTIOUS SCANS
	<input type="checkbox"/> Treadmill	<input type="checkbox"/> Hida Only	<input type="checkbox"/> Liver Scan	<input type="checkbox"/> Whole Body	<input type="checkbox"/> Uptake and Scan	<input type="checkbox"/> Indium WBC
	<input type="checkbox"/> Adenosine/Lexiscan	<input type="checkbox"/> Hida with CCK	<input type="checkbox"/> Hemangioma	<input type="checkbox"/> 3 Phase	(Include Bloodwork)	<input type="checkbox"/> Ceretec WBC
	<input type="checkbox"/> Dobutamine			<input type="checkbox"/> SPECT (Area)	<input type="checkbox"/> I-131 Hyperthyroid	<input type="checkbox"/> Gallium
	<input type="checkbox"/> MUGA	TUMOR LOCALIZATION	GI STUDIES	<input type="checkbox"/> Bone Marrow Scan	Therapy	
	<input type="checkbox"/> Viability	<input type="checkbox"/> MIGB	<input type="checkbox"/> Meckel's			
	PARATHYROID (Include Bloodwork)	<input type="checkbox"/> Octreoscan	<input type="checkbox"/> Gastric Empty	LUNG STUDIES	OTHER (Specify Type)	
	<input type="checkbox"/> PTH, Calcium	<input type="checkbox"/> Sentinel Node (Breast/Melanoma)	<input type="checkbox"/> GI Bleed	<input type="checkbox"/> VQ		
				<input type="checkbox"/> Quantitative		

**** Please include films and/or reports of other studies that would allow correlation ****

WOMEN'S IMAGING	DIGITAL MAMMOGRAM	Screening
		<input type="checkbox"/> Diagnostic w/ Ultrasound indicated
		<input type="checkbox"/> Needle Localization
BONE DENSITY	<input type="checkbox"/> DEXA Scan	<input type="checkbox"/> Breast Ultrasound



For appointment information, or to reschedule, call 817-255-1999.

EXAM PREPARATIONS

Bring this form to your appointment, and inform our radiology technologists of any allergies you may have or if you are pregnant or nursing. Please plan to arrive 30 minutes ahead of the scheduled exam time to register for the exam at Central Registration.

Computed Tomography (CT)

Come to the Radiology Department at least one day prior to your exam to receive oral contrast and instructions.

If you have a history of allergy to contrast media (X-ray dye), please contact your physician the day before the examination. Nursing mothers must stop breast feeding for 48 hours after study.

Head, Neck, Chest: Nothing by mouth 2 hours prior to study.

Abdominal, Pelvis: Nothing to eat or drink 4 hours prior to your examination. If you have had any barium studies within the last 3 days, your physician should prescribe a laxative.

Magnetic Resonance Imaging (MRI)

Inform us if you have a pacemaker, artificial heart valves, any metal objects in your body, are pregnant or nursing. Without contrast: No preparation is required. For abdominal MRI, do not eat or drink 4 hours before your exam.

Pelvic or Obstetric Ultrasound

This examination requires a full bladder. One hour before your appointment, empty your bladder and immediately drink 32 oz. of any liquid. Please do not empty your bladder until after your examination is completed. *No preparation is necessary for patients more than 16 weeks pregnant.*

Abdominal Ultrasound

Do not eat, drink, smoke or chew gum after midnight the night before your appointment.

Barium Enema

Must visit Radiology Department by noon, the day before your exam. Follow instructions on enema prep kit.

Breast Studies

Do not use deodorant, powder or lotion in the breast and underarm area. For your comfort, two-piece outfits are recommended. Please bring any previous mammogram films or call that office and have them sent to us at the North Hills Hospital, 4375 Booth Calloway Rd., North Richland Hills, TX 76180.

Dexa Scan/Bone Density - Located in Women's Imaging

No calcium supplements on the day of the scan. No barium contrast studies five days before the exam. Please do not wear clothing with metal or zippers.

Upper GI/Small Bowel Series

Please do not eat or drink after midnight until after your procedure is completed the following day.

IVP

1) Take 4 Dulcolax tablets (over the counter item available at your pharmacy) at 8 p.m. the day before your procedure. 2) Do not eat or drink after 8 p.m. except clear liquids. 3) Nothing to drink 2 hours before exam.

Nuclear Medicine

1) Bone Scan - You may eat and drink. Your first appointment is for the injection. You will return 3 hours later for the scan, which takes about 1 hour.
 2) Lung Scan - You will have to bring a chest X-ray with you that has been taken within 24 hours, or have one taken while you are here.
 3) HIDA - Do not eat or drink after midnight the night before or morning of the exam. Ask your doctor about taking medications.
 4) Thallium (Stress or Adenosine) - Do not eat or drink after midnight the night before or the morning of the exam. Ask your doctor about taking medications.
 5) Thyroid Uptake & Scan - Do not eat or drink after midnight the night before or the morning of the exam. You should be off all thyroid medications for this exam.



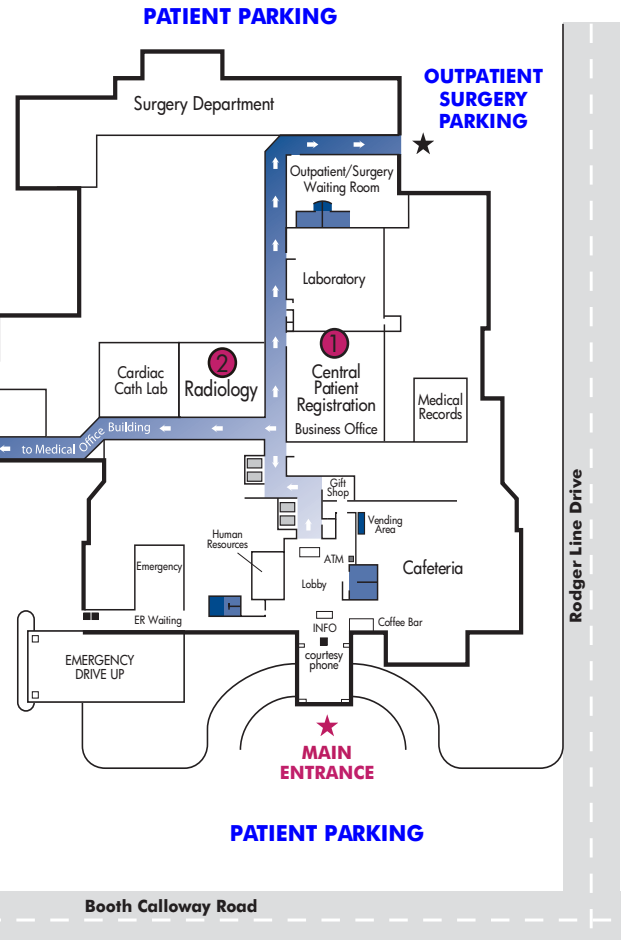
4401 Booth Calloway Road
 North Richland Hills, TX 76180
northhillshospital.com

- Hospital Entrances
- Elevators
- Restrooms
- Vending Machines
- ATM/Cash Machine
- Courtesy phone

PATIENT PARKING



PATIENT PARKING



For questions about your appointment, call scheduling at 817-255-1999.

For questions about the procedure or preparations, please call Radiology at 817-255-1855.