



Park Place MRI
 6800 North Dale Mabry Hwy.
 Suite #144
 Tampa, FL. 33614
 Phone: 813-886-9999
 Fax: 813-885-2800

Patient's Name: _____ First _____ Last _____
 Date of Birth: _____ Home # _____ Alt. # _____
 Authorization # _____
 Appointment Date & Time Requested: _____

TO AVOID BEING RESCHEDULED, PLEASE FAX THIS PRESCRIPTION ALONG WITH
 AUTHORIZATION/REFERRAL (IF REQUIRED) BY 5:00PM. THE DAY PRIOR TO THE EXAM

PHYSICIAN'S PRESCRIPTION

MRI/MRA

- Without Contrast With & Without Contrast
- Abdomen with attention to: _____
- Brain
- Breast
- Cervical Spine
- Chest
- IACs
- Lower Extremity _____ RT ___ LT ___
- Attention: _____
- Lumbar Spine
- MRCP
- Neck - Soft Tissue
- Orbits
- Pelvis
- Pituitary Gland
- Thoracic Spine
- TMJ
- Upper Extremity _____ RT ___ LT ___
- Attention: _____
- Other: _____
- MRA Abdomen MRV Abdomen
- MRA Aorta Run Off MRV Brain
- MRA Brain MRV Lwr Ext
- MRA Lwr Ext MRV Neck
- MRA Neck MRV Pelvis
- MRA Pelvis MRV Renals
- MRA Renals
- Other _____

DIAGNOSIS CODE(S): _____

Physician's Printed Name _____

CT

- Without Contrast With & Without Contrast
- Abdomen with attention to: _____
- Brain
- Cervical Spine
- Chest
- IAC / Mastoid / Orbits
- Lower Extremity _____ RT ___ LT ___
- Attention: _____
- Lumbar Spine
- Neck - Soft Tissue
- Orbits
- Pelvis
- Sinus
- Thoracic Spine
- Upper Extremity _____ RT ___ LT ___
- Attention: _____
- Other: _____

XRAY

- Abdomen (KUB)
- Abdomen Complete
- Ankle _____ RT ___ LT ___ VW
- Cervical _____ VW
- Chest _____ VW
- Elbow _____ RT ___ LT ___ VW
- Facial bones
- Femur _____ RT ___ LT ___
- Foot _____ RT ___ LT ___ VW
- Forearm _____ RT ___ LT ___
- Hand _____ RT ___ LT ___ VW
- Head
- Heel / Calcaneus _____ RT ___ LT ___
- Hip _____ RT ___ LT ___ VW
- Humerus _____ RT ___ LT ___
- Knee _____ RT ___ LT ___ VW
- Lumbar _____ VW
- Mandible _____ VW
- Mastoids
- Neck - Soft Tissue
- Orbits
- Pelvis _____ RT ___ LT ___
- Ribs _____ RT ___ LT ___ VW
- Sacroiliac Joint
- Sacrum
- Shoulder _____ RT ___ LT ___ VW
- Sinuses _____ VW
- Skull
- Tibia / Fibula _____ RT ___ LT ___
- Thoracic _____ VW
- Wrist _____ RT ___ LT ___ VW

ULTRASOUND

- Abdomen complete
- Abdomen limited
- Arterial LE _____ RT ___ LT ___
- Arterial UE _____ RT ___ LT ___
- Breast _____ RT ___ LT ___
- Carotid
- Echo
- Holter Monitoring
- Non-Vascular Extremity _____ RT ___ LT ___
- OB (gestational age only)
- Pelvic
- Retroperitoneal
- Testicular
- Thyroid/Parathyroid/Parotid
- Transvaginal (inc. pelvis)
- Venous _____ RT ___ LT ___
- COMPARISON REQUIRED
- Please compare with exam _____ / _____ / _____
- Scan done on _____ / _____ / _____
- Patient has films / report _____
- Contact _____ for films / report.

Date _____

Physician's Signature _____