**Park Place MRI & Diagnostics**
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. # _____

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

# PHYSICIAN'S PRESCRIPTION

## HIGH-FIELD MRI

☐ W/ contrast ☐ W/O contrast

☐ Abdomen attn to: _____
☐ Brain
☐ Brain (trauma w/ SWI)
☐ Chest
☐ IACs
☐ MRCP
☐ Neck - Soft Tissue
☐ Orbits
☐ Pelvis
☐ Pituitary Gland
☐ TMJ
☐ Cervical w/Alar
☐ Cervical
☐ Cervical w/Flex & Ext
☐ Lumbar Weight Bearing
☐ Lumbar
☐ Thoracic

### EXTREMITIES

| | | | | | |
|---|---|---|---|---|---|
| ☐ Elbow | R | L | ☐ Ankle | R | L |
| ☐ Hand | R | L | ☐ Foot | R | L |
| ☐ Shoulder | R | L | ☐ Hip | R | L |
| ☐ Wrist | R | L | ☐ Knee | R | L |
| **Arthrogram** | **Y** | **N** | **Arthrogram** | **Y** | **N** |

Other _____

## MRA / MRV

☐ MRA Abdomen
☐ MRA Brain
☐ MRA Lwr Ext
☐ MRA Aorta Run Off
☐ MRA Neck
☐ MRA Pelvis
☐ MRA Renals
☐ MRV Brain

Other _____

## 16 SLICE CT SCAN

☐ W/ contrast ☐ W/O contrast

☐ Abdomen attn to: _____
☐ Pelvis
☐ Urogram
☐ Brain
☐ Chest
☐ IAC/ Mastoid/ Orbits
☐ Neck- Soft Tissue
☐ Sinus/ Facial Bones
☐ Cervical
☐ Lumbar
☐ Thoracic

☐ Cardiac (Calcium) Score

### EXTREMITIES

| | | | | | |
|---|---|---|---|---|---|
| ☐ Elbow | R | L | ☐ Ankle | R | L |
| ☐ Hand | R | L | ☐ Foot | R | L |
| ☐ Shoulder | R | L | ☐ Hip | R | L |
| ☐ Wrist | R | L | ☐ Knee | R | L |

Other _____

## CTA

☐ CTA Abdomen
☐ CTA Carotid
☐ CTA Pelvis
☐ CTA Lwr Ext R L
☐ CTA Upr Ext R L
☐ CTA Brain
☐ CTA Chest
☐ CTA Runoff

Other: _____

## XRAY

(Vw = # of Views)

☐ Abdomen (KUB)
☐ Chest Vw____
☐ Heel R L Vw____
☐ Orbits
☐ Ribs R L Vw____
☐ Sacroiliac Joint

☐ Cervical Vw____
☐ Lumbar Vw____
☐ Thoracic Vw____

☐ Elbow R L Vw____
☐ Forearm R L Vw____
☐ Hand R L Vw____
☐ Humerus R L Vw____
☐ Shoulder R L Vw____
☐ Wrist R L Vw____

☐ Ankle R L Vw____
☐ Femur R L Vw____
☐ Foot R L Vw____
☐ Hip R L Vw____
☐ Knee R L Vw____
☐ Tibia/Fibula R L Vw____

Other: _____

## ULTRASOUND

☐ Abdomen complete
☐ Abdomen limited attn to: _____
☐ Aorta
☐ Arterial Lwr Ext R L
☐ Arterial Upr Ext R L
☐ Carotid
☐ Non-Vascular Lwr Ext R L
☐ Non-Vascular Upr Ext R L
☐ OB __1st Tri ___2-3 Tri
☐ OB Transvaginal (1st Tri Only)
☐ Pelvic and Transvaginal
☐ Pelvic Only
☐ Prostate (Transrectal)
☐ Renal Artery Doppler
☐ Retroperitoneal (Kidneys & Bladder)
☐ Soft Tissue
☐ Testicular
☐ Thyroid
☐ Transvaginal Only
☐ Venous Upr Ext R L
☐ Venous Lwr Ext R L

☐ COMPARISON REQUIRED

☐ Scan done on ____/____/____

☐ Patient has films / report

☐ Contact _____ for films / report.

DIAGNOSIS CODE(S): _____

_____
Physician's Printed Name

_____
Physician's Signature

_____
Date