Saint Francis Outpatient Diagnostic Services

❑ **SFH Outpatient Scheduling** Ph (901) 765-3279 FAX (901) 765-2363
❑ **Total Care Scheduling** Ph (901) 767-0505 FAX (901) 680-8421
❑ **Park Avenue Scheduling** Ph (901) 767-0505 FAX (901) 761-1335
Tax I.D. 75-2522262

□ **STAT** Call Report to _____
□ Fax Report to _____
□ Park Avenue to schedule Patient
□ Total Care to schedule Patient
□ Outpatient to schedule Patient
□ Precert Patient
□ Walk-In Patient
□ Courier/FedEx □ Films □ CD-ROM
□ Send with patient □ Film □ CD-ROM

Early morning, evening & Saturday Hours for MRI

Appointment Date: _____ Time: _____ AM / PM Follow-up Appt with Physician Date: _____

Patient Name: _____ □ M □ F Date of Birth: _____

Home Phone: _____ Alternate Phone: _____

Primary Insurance: _____ Precert/Referral # _____

Referring Physician: _____ Physician Phone: _____

Exam(s): _____

Symptoms/Diagnosis: _____

REFERRING PHYSICIAN SIGNATURE (Required) _____ **Date** _____ **Time** _____

Magnetic Resonance Imaging (MRI)*

MRI Weight Limits : MRI - Highfield (closed) 350 lbs, MRI - OPEN 500 lbs

CONTRAST*: ❑ With/without ❑ Without ❑ Radiologist's discretion
*If not checked, Radiologist's discretion will be used.

❑ **RIGHT**	❑ **LEFT**	❑ **BOTH**
❑ WRIST	❑ FOREARM	❑ ELBOW
❑ SHOULDER	❑ BREAST IMPLANT	❑ HUMERUS
❑ FOOT	❑ ANKLE	❑ KNEE
❑ TIB/FIB	❑ FEMUR	❑ HIP
❑ CERVICAL	❑ THORACIC	❑ LUMBAR
❑ ABDOMEN	❑ PELVIC	❑ CHEST ❑ BRAIN
❑ ORBITS	❑ IAC	❑ SELLA ❑ TMJ
❑ MRCP	OTHER _____	

MRA of
❑ HEAD ❑ NECK ❑ RENAL ❑ ABDOMINAL
❑ THORACIC ❑ OTHER _____

ULTRASOUND

❑ COMPLETE ABDOMINAL ❑ GALLBLADDER/LIVER ONLY
❑ OB, TRANSVAGINAL IF NEEDED ❑ AORTA ❑ RENAL
❑ NON-OB PELVIC, TRANSVAGINAL IF NEEDED
❑ TRANSVAGINAL ONLY ❑ BREAST ❑ WITH DOPPLER
❑ SCROTUM WITH DOPPLER ❑ THYROID
❑ OTHER _____
❑ CAROTID
❑ LOWER EXTREMITY ARTERIAL ❑ UPPER EXTREMITY ARTERIAL
❑ LOWER EXTREMITY VENOUS ❑ UPPER EXTREMITY VENOUS
❑ UNILATERAL ❑ L ❑ R ❑ BILATERAL

MAMMOGRAPHY*

❑ BREAST SCREENING MAMMOGRAM
❑ DIAGNOSTIC MAMMOGRAM
(BREAST ULTRASOUND IF NEEDED)
❑ BREAST ULTRASOUND

*American College of Radiology Accredited

NUCLEAR MEDICINE

❑ BONE SCAN ❑ BONE SCAN W/ FLOW
❑ HEPATOBILIARY ❑ OTHER _____

CAT SCAN (CT)

CT Weight Limit 550 lbs

CONTRAST*: ❑ With/without ❑ Without ❑ With ❑ Radiologist's discretion
*If not checked, Radiologist's discretion will be used.

❑ CARDIAC SCORING
❑ ABDOMEN ONLY/SPECIAL ATTENTION TO _____
❑ ABDOMEN and PELVIS ❑ PELVIS ONLY
❑ NECK ❑ BRAIN
❑ SINUSES ❑ ORBITS
❑ IAC'S ❑ CERVICAL
❑ THORACIC ❑ LUMBAR
❑ EXTREMITY _____ ❑ 3-D RECON _____
❑ CHEST ❑ RENAL STONE
❑ FACIAL BONES

❑ CARDIAC SCORING _____

CTA of
❑ HEAD ❑ CHEST ❑ NECK
❑ ABD ❑ ABD c Run Off ❑ RENAL

XRAY/FLUOROSCOPY

Weight Limit 300 lb ❑ L ❑ R

ROUTINE X-RAY specify: _____
❑ ARTHROGRAM _____
MYELOGRAM ❑ CERVICAL ❑ LUMBAR ❑ THORACIC
❑ BARIUM ENEMA ❑ BARIUM ENEMA WITH AIR
❑ BARIUM SWALLOW ❑ IVP ❑ UPPER GI SERIES
❑ SMALL BOWEL FOLLOW THROUGH ❑ DEXA (Bone Density)

OTHER _____

This requested study is consistent with generally accepted principals of professional medical practice. Patient must present this form on the day of their test. Failure to do so will result in a delay and possible rescheduling of the appointment.

REV 07/11
1000-488

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❑ SHOULDER	❑ BREAST IMPLANT	❑ HUMERUS	
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MRA of
❑ HEAD ❑ NECK ❑ RENAL ❑ ABDOMINAL
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CTA of
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INSTRUCTION SHEET FOR SCHEDULER TO REVIEW AND PROVIDE TO PATIENT

www.totalcarememphis.com
www.saintfrancishosp.com

MAGNETIC RESONANCE IMAGING (MRI) and MRA

1. Bring recent films if available.
2. For head or orbit scan, do not wear eye makeup.

MYELOGRAM/ARTHROGRAM

1. No aspirin or blood thinner 7 days before exam.
2. Take all medications, drink plenty of water.

MYELOGRAM

1. Patient will be unable to drive after the exam, please provide for transportation.
2. Nothing to eat after midnight the night before the exam.

GI SERIES (STOMACH)

1. Nothing by mouth after midnight the night before the exam.
2. Nothing by mouth the day of the exam.

CAT SCAN (CT)

ABDOMEN AND/OR PELVIS

1. Arrive 1 hour early for prep.

MAMMOGRAPHY

1. On the day of the exam, do not wear deodorants, oils, powders or perfumes.
2. We recommend that the patient discontinue caffeine for three days prior to the exam. To alleviate further discomfort, schedule your exam to fall as close after your menstrual cycle as possible.
3. Must bring previous Mammography films of prior studies not at this facility.

ULTRASOUND

ABDOMINAL/PELVIC (2 EXAMS), COMPLETE
ABDOMINAL, GALL BLADDER/LIVER ONLY

1. Nothing by mouth after midnight or 6 hours prior to exam.

PELVIC AND/OR OB

1. Do not urinate-a full bladder is necessary for this exam.

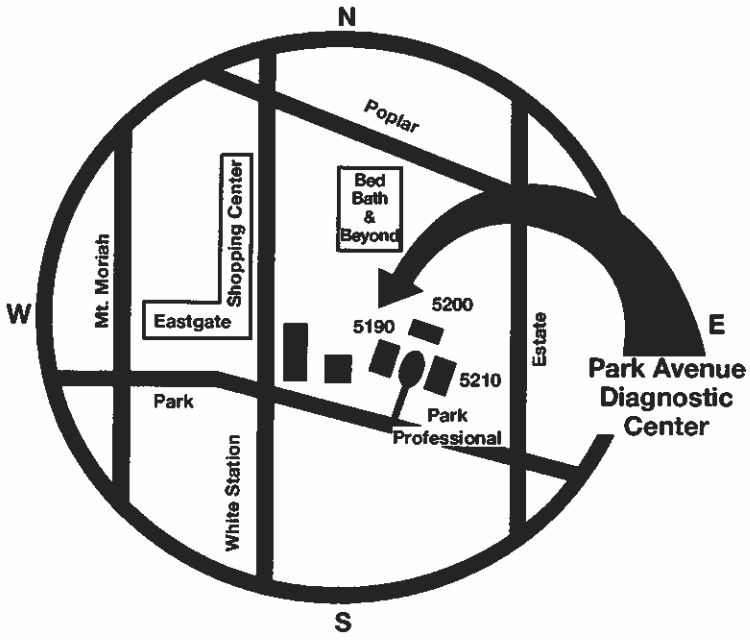
MRCP of ABP (Magnetic Resonance Cholangiopantography)

1. Nothing by mouth 4 hours before exam.

PARK AVENUE DIAGNOSTIC

From I-240 at Poplar Avenue:

Exit Poplar Avenue west and follow to White Station. Turn Left on White Station and continue to Park Avenue. Turn Left on Park Avenue. **Park Professional Plaza** is 500 feet east of this intersection on the left north side of Park Avenue. **Park Avenue Diagnostic Center** is located at 5190 Park Avenue (first building on the left in cove).

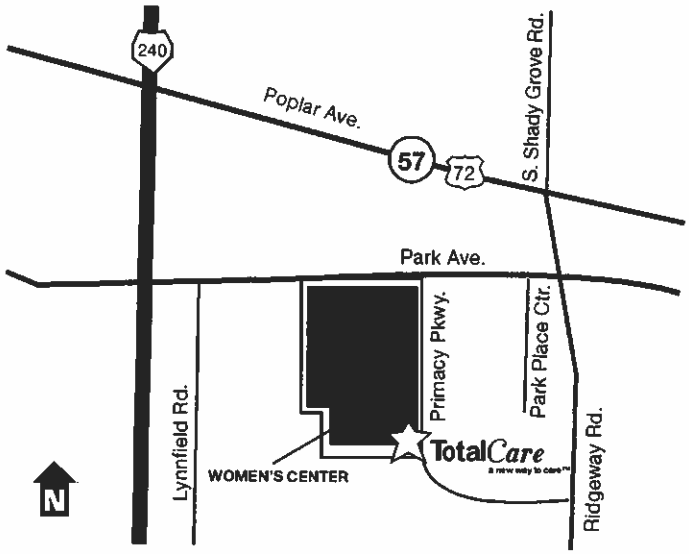


5190 Park Avenue
Memphis, TN 38119

SAINT FRANCIS HOSPITAL/TOTAL CARE

To find Total Care:

TotalCare is conveniently located on the campus of Saint Francis Hospital - Memphis on the first floor of the O'Ryan Building. The entrance is on Park Avenue, near Primacy Parkway. Free valet parking and reserved parking spots are available for Total Care Patients.



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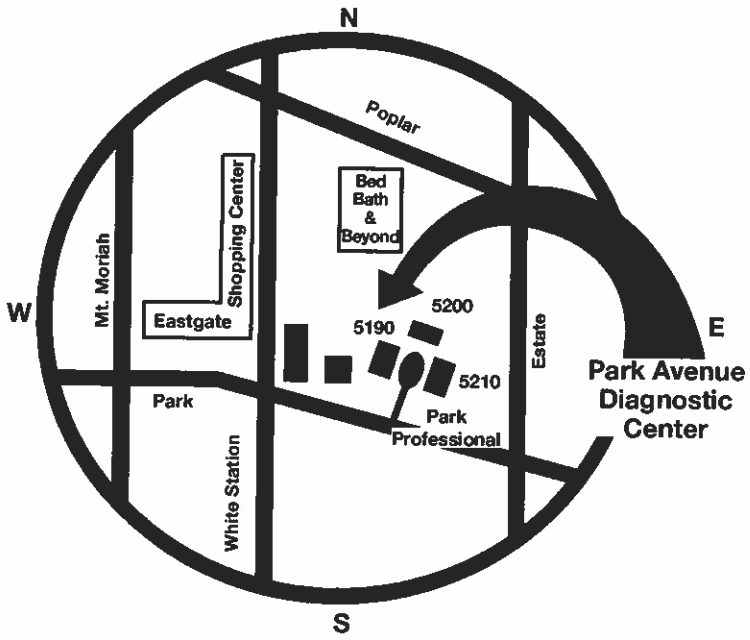

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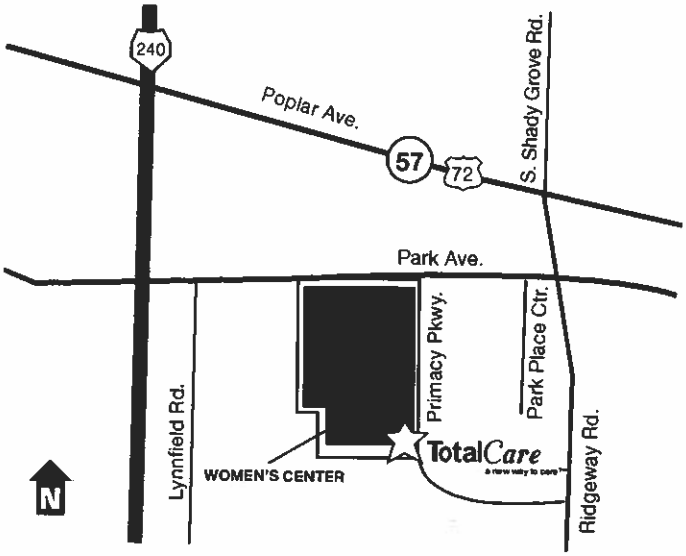

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