Diagnostic Imaging Services
Specialists in Outpatient Radiology

Additional Information Available at www.disnola.com

SCHEDULE BY FAX FORM

DIAGNOSTIC TESTING WILL NOT BE PERFORMED WITHOUT A SIGNED PHYSICIAN'S ORDER

PATIENT NAME ______________________ DATE: __________

WORK PHONE: ____________ HOME PHONE ____________ D.O.B ____________

WRITTEN DIAGNOSIS (REQUIRED) ______________ DIAGNOSIS CODE (ICD-9) (REQUIRED) ________

PHYSICIAN'S SIGNATURE (REQUIRED) ______________________ M.D.

WORKMEN'S COMP ________ ATTY. ________ AUTHORIZATION # ____________

PATIENT INSURANCE ____________ POLICY # ____________ GROUP # ____________

REFERRING PHYSICIAN (PLEASE PRINT) ______________________ M.D.

ADDRESS ______________ TELEPHONE ____________ FAX ____________

IF MRI, CT or IVP w/ contrast please provide BUN______ & Creatinine ______ levels.

CT Scan
- Head ☐ w/o ☐ w & w/o
- Soft T-Neck ☐ w ☐ w/o
- Chest ☐ w ☐ w/o
- Abdomen ☐ w/o ☐ w & w/o
- Pelvis ☐ w/o ☐ w & w/o
- Sinus ☐ w/o
- IAC ☐ w ☐ w/o
- C Spine ☐ w ☐ w/o
- L Spine ☐ w ☐ w/o
- T Spine ☐ w ☐ w/o
- ☐ 3-D Reconstruction
- ☐ Extremity ☐ w ☐ w/o
- ☐ Other ______________

CTA
- ☐ Aorta ☐ w ☐ w/o
- ☐ Renal ☐ w ☐ w/o
- ☐ Runoff ☐ w ☐ w/o
  - Lower Ext: ____L ____R only
- ☐ Carotid Artery ☐ w & w/o
- ☐ Upper Ext: ____L ____R
- ☐ Other ______________

Ultrasound
- ☐ CHECK HERE IF DOPPLER NEEDED
- ☐ Abdominal
  - ☐ Limited(Gallbladder/Liver)
- ☐ Appendix
- ☐ Breast ____ Left ____ Right
- ☐ Pelvis
- ☐ Transvaginal
- ☐ OB (1st Trimester) Transvaginal
- ☐ OB (2nd/3rd Trimester)
- ☐ Carotid
- ☐ Thyroid
- ☐ Testicular w/ doppler
- ☐ Aorta
- ☐ Kidney
- ☐ Kidney w/ renal artery doppler
- ☐ Hysterosonogram

Non-Inv. Venous
- ☐ Arms ____Left ____Right
- ☐ Legs ____Left ____Right

Non-Inv. Arterial (w/ABI)
- ☐ Arms ____Left ____Right
- ☐ Legs ____Left ____Right

Extremity non-vascular
- Body Part ______________
- ☐ Other ______________

MRA
- ☐ Aorta (with only)
- ☐ Renal (with only)
- ☐ Runoff
  - Lower Ext: ____L ____R
- ☐ Upper Ext: ____L ____R
- ☐ Circle of Willis (w/o only)
- ☐ Carotid Artery ☐ w/o ☐ w & w/o
- ☐ MRV______________
- ☐ Non-contrast Renal MRA (Uptown Only)

MRI

Head
- ☐ Brain ☐ w/o ☐ w & w/o
- ☐ IAC ☐ w/o ☐ w & w/o
- ☐ MS Protocol ☐ w/o ☐ w & w/o
- ☐ Nasopharynx ☐ w/o ☐ w & w/o
- ☐ Orbit ☐ w/o ☐ w & w/o
- ☐ Parotid Gland ☐ w/o ☐ w & w/o
- ☐ Pituitary Gland ☐ w/o ☐ w & w/o
- ☐ Sinus ☐ w/o ☐ w & w/o
- ☐ Other ______________

Body
- ☐ Neck ☐ w/o ☐ w & w/o
- ☐ Chest ☐ w/o ☐ w & w/o
- ☐ Abdomen ☐ w/o ☐ w & w/o
- ☐ Pelvis ☐ w/o ☐ w & w/o
- ☐ GYN Pelvis ☐ w/o ☐ w & w/o

Spine
- ☐ Brachial Plexus ☐ w/o ☐ w & w/o
  - ____Left ____Right
- ☐ Cervical Spine ☐ w/o ☐ w & w/o
- ☐ Thoracic Spine ☐ w/o ☐ w & w/o
- ☐ Lumbar Spine ☐ w/o ☐ w & w/o

Joint (shoulder,elbow, wrist,hip,knee,ankle)
- ☐ Upper Extremity: ____L ____R
- ☐ Lower Extremity: ____L ____R
- ☐ MR Arthrography
  - Body Part ______________

Non-Joint (humerus, forearm,femur,leg)
- ☐ Upper Extremity: ____L ____R
- ☐ Lower Extremity: ____L ____R
  - Body Part ______________

X-Ray
- ☐ Chest (2 view)
- ☐ Chest (1 view)
- ☐ Cervical Spine
  - ☐ Flex & Ext. Only
- ☐ Thoracic Spine with Flex Extension
- ☐ Lumbar Spine ☐2 views ☐more than 2 views
- ☐ With Flex & Ext.
- ☐ Sacrum/Coccyx
- ☐ KUB
- ☐ Flat & Erect Abdomen
- ☐ Pelvis
- ☐ Bone Age
- ☐ Skull ______ Orbits ______Sinuses
- ☐ Other ______________

	Circle Side	
☐ Fingers	Left	Right
☐ Hand	Left	Right
☐ Wrist	Left	Right
☐ Forearm	Left	Right
☐ Elbow	Left	Right
☐ Humerus	Left	Right
☐ Shoulder	Left	Right
☐ Ribs	Left	Right
☐ Hips	Left	Right
☐ Femur	Left	Right
☐ Knee	Left	Right
☐ Lower Leg	Left	Right
☐ Ankle	Left	Right
☐ Foot	Left	Right
☐ Toe	Left	Right

Fluoroscopy
- ☐ BE
- ☐ BE with Air
- ☐ Esophogram
- ☐ UGI
- ☐ Small Bowel
- ☐ IVP

Special Procedures:
- ☐ CT Myelogram ☐Cerv.☐Lum.☐Thor.
- ☐ Arthrogram ____MR ____CT
  - Body Part ______________
- ☐ Hysterosalpingogram
- ☐ CT Calcium Scoring
- ☐ Lumbar Punctures

Nuclear Medicine
- ☐ CHECK HERE IF SPECT IS NEEDED
- ☐ Bone, Whole body
- ☐ Bone, 3 phase
- ☐ Gallium
  - ☐ Whole Body ☐ Limited
- ☐ Wall Motion MUGA
- ☐ Parathyroid Scan
- ☐ Hyperthyroid Treatment (I-131)
- ☐ Gastric Emptying
- ☐ HIDA ☐ HIDA w/ EF
- ☐ Liver-Spleen
- ☐ Liver Hemangioma Imaging
- ☐ Mag Renal
- ☐ Mag 3 Renal w. Lasix
- ☐ Renal Scan (Captopril)
- ☐ Thyroid Scan
- ☐ Thyroid Scan w/ Uptake
- ☐ Total Body Scan (I-131)
- ☐ Other______________

Mammography
- ☐ Screening Mammography
- ☐ Diagnostic Mammography
  - ____ Left ____ Right ____Bilat
- ☐ Breast US if needed
  - ____ Left ____ Right ____Bilat

Bone Density
- ☐ AP Spine & Prox Femur
- ☐ IVA (WC & Uptown only)

Centralized Scheduling Department
Phone: (504) 883-5999
Fax: (504) 883-5364

YOUR PATIENT'S EXAMINATION IS SCHEDULED AT OUR:

☐ METAIRIE	☐ WOMEN'S CENTER	☐ UPTOWN	☐ MARRERO
3625 HOUMA BLVD.	4241 VETERANS BLVD., STE. 100	3437 PRYTANIA ST.	925 AVENUE C
METAIRIE LA 70006	METAIRIE LA 70006	NEW ORLEANS LA 70115	MARRERO LA 70072
504-888-7921	504-459-3222	504-883-5353	504-459-3200

Appt. Date: ____________ Time ____________ Today Date ____________ Initials ________