

Diagnostic Radiology Order Form

125C Wamsutta Mill Rd - Morganton, NC 28655 - Phone (828) 430-3511 Fax (828) 368-4523 Hours M-Th 8am - 5pm, Fri 8am - 12pm

Please Bring This Form With You To Your Appointment

Patient Information

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Referring Physician Information

Reason for exam(s) _____ Prep Required: Yes No

Physician Name _____ Physician Phone # _____ STAT Reading: S O

STAT Call _____ STAT Fax _____ Send Images With Patient: S O

Physician Address: _____

	Ultrasound	X-Ray	X-Ray (Continued)
Echocardiogram		Chest <input type="checkbox"/> PA <input type="checkbox"/> PA & Lateral	Tib/Fib <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B
Carotid Duplex		Abdomen <input type="checkbox"/> Flat <input type="checkbox"/> Upright	Ankle <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B
Arterial Unilateral with ABI (lower)		Acute Abdominal Series	Foot <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B
Arterial Bilateral with ABI (lower)		Pelvis	Other: Please Fill in Below
Arterial Unilateral (upper)		Ribs <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	
Arterial Bilateral (upper)		Cervical Spine - Routine	Other
Venous Unilateral (upper or lower)		Cervical Spine - Flex/Ext	
Venous Bilateral (upper or lower)		Thoracic Spine	
Aorta Duplex		Lumbar Spine - Routine	
Ankle Brachial Index (ABI)		Lumbar Spine - Flex/Ext	
CIMT/Carotid Screening		Clavicle <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	
CIMT plus Carotid/AAA/ABI		Shoulder <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	
Complete Abdomen		Humerus <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	
Right Upper Quadrant		Elbow <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	
Renal		Forearm <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	
Renal Artery/Renal		Wrist <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	
Bladder (Pre & Post Void)		Hand <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	
Pelvic Complete w/Transvaginal		Hip <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	
Testicular/Scrotum		Femur <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	
Extremity Non-Vascular (Soft Tissue)		Knee <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	

Physician Signature _____ Date _____

INFORMATION

Please bring this referral form with you to your appointment.

Please bring your health insurance information: forms and cards.

Please bring a photo ID.

Please bring any previous exam images and/or reports with you.

Please leave anything valuable at home. SonoCare is not responsible for lost belongings.

If you are pregnant, please inform our staff prior to your exam.

If you need to reschedule your appointment, please call at least 24 hours in advance.

PATIENT PREPARATION AND DIETARY RESTRICTIONS

EXAM

Abdominal Ultrasound

PATIENT EXAM PREPS

Please do not eat or drink anything 6-8 hours prior to exam. Drink plenty of clear fluids and avoid fatty foods the day prior to your exam.

Pelvic/Bladder Ultrasound

There are no dietary restrictions, however, patient must complete drinking 48 oz. of liquid one hour prior to exam. Patient should not empty bladder after they have started drinking.

Renal Artery Ultrasound

Please do not eat or drink anything 8 hours prior to exam. The day prior to your exam, drink plenty of clear fluids, avoid fatty foods and carbonated liquids and have a light meal.

Abdominal Aorta Ultrasound

Please do not eat or drink anything 6-8 hours prior to exam. The day prior to your exam, drink plenty of clear fluids, avoid fatty foods and carbonated liquids.

Renal Ultrasound

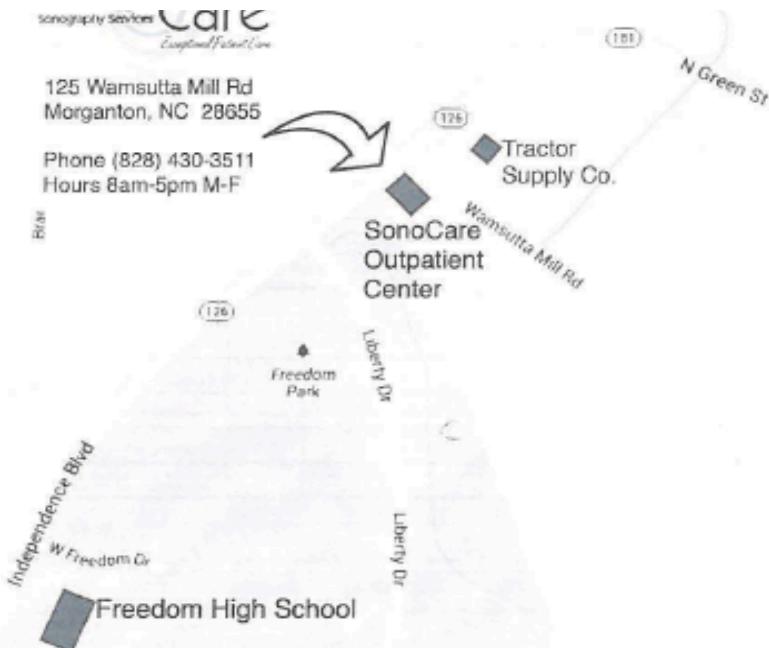
Please drink 32 oz. of water the day of your test.

WHEN WILL I KNOW MY RESULTS?

Your exam will be interpreted by our board-certified radiologists at Imaging Partners. A full written report will be provided to your doctor within 24-48 hours after your exam. Someone from your doctor's office will contact you to discuss the results of your exam.

MAP & DRIVING DIRECTIONS

FROM I-40: Take exit 100 from I-40 (Jamestown Rd exit). Continue north on Jamestown Rd. After you cross Route 70 Jamestown Rd. will become Independence Blvd. Continue on Independence Blvd. SonoCare will be on your right after you pass Freedom Park.



E PARKER RD: From E. Parker Rd. turn right onto S. Sterling St. S. Sterling St. will become S. Green St. Continue onto N Green St. Turn left onto Independence Blvd (Hwy 126). SonoCare will be on your left after you pass Tractor Supply.