



# LONGHORN IMAGING



Please Select Facility

- BASTROP  CEDAR PARK  JAMES CASEY ST  KILLEEN  ONION CREEK  PARMER LANE  ROLLINGWOOD  MARBLE FALLS

**SCHEDULING: 512-444-8900 • FAX: 512-444-7244 • EMAIL: referrals@longhornimaging.com**

Patient Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Phone # \_\_\_\_\_ Gender \_\_\_\_\_

Insurance \_\_\_\_\_ Insurance ID# \_\_\_\_\_

Referring Physician Signature: \_\_\_\_\_

Ordered Date: \_\_\_\_\_

**X**

**X**

**STAT Call** Pager or Cell Phone # \_\_\_\_\_

May modify exam at radiologists discretion if clinically indicated.

Scan as ordered.

**STAT Fax**

DIAGNOSIS  
OR ICD-10  
CODE(S) \_\_\_\_\_

REASON  
FOR  
EXAM/NOTES \_\_\_\_\_

Deliver CD to Office

Send CD w/ Patient

Please Compare to Previous

PLEASE FAX SIGNED ORDERS, DEMOGRAPHICS, INSURANCE AND CLINICALS

(PRINT) Referring Dr: \_\_\_\_\_ Please Print Legibly

Referring Office Contact: \_\_\_\_\_

Referring Office:

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_ Please Print Legibly

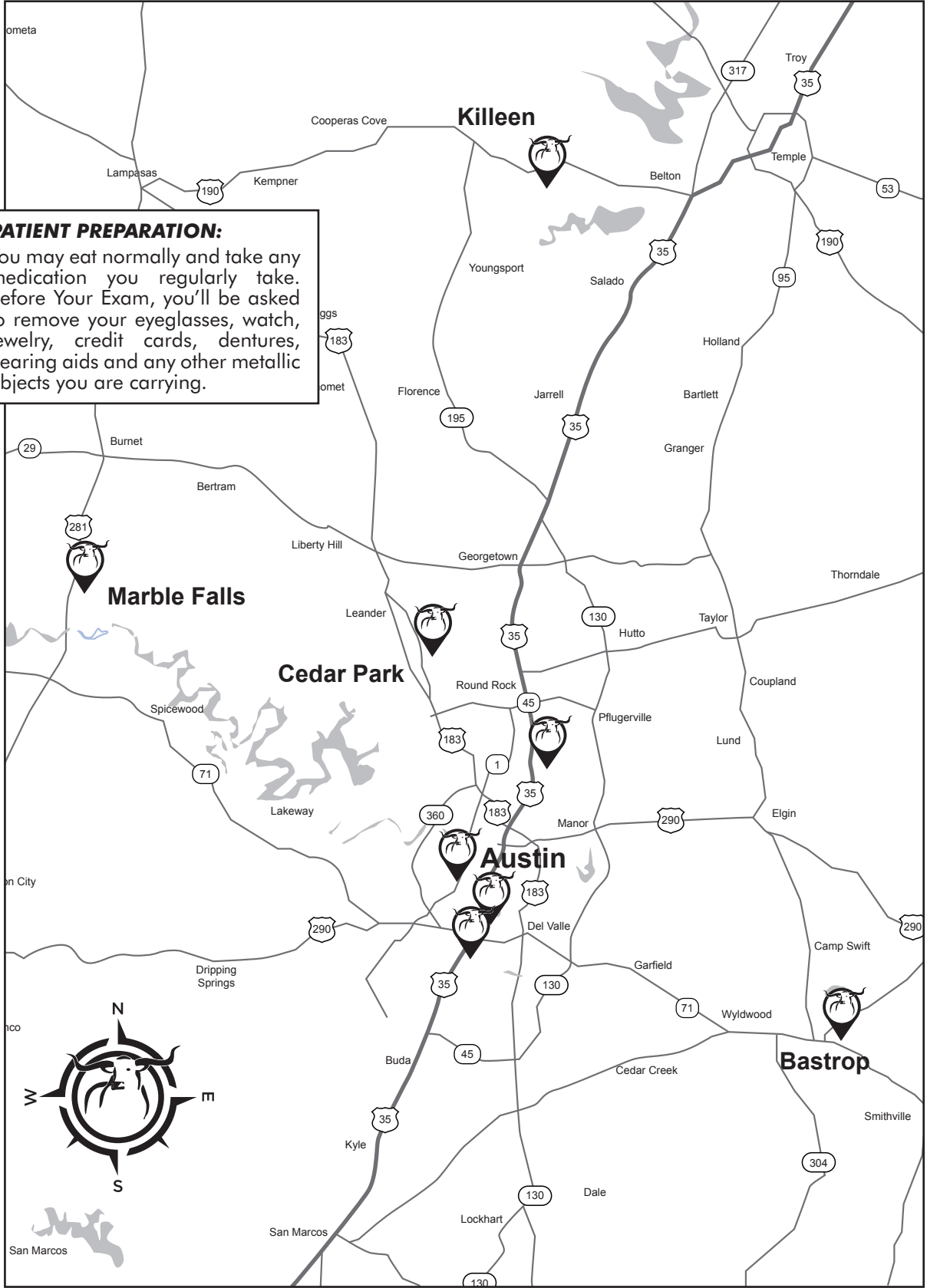
MRI	CT	ULTRASOUND	X-RAY																																																																																																																					
<input type="checkbox"/> <b>1.5T MRI</b> <input type="checkbox"/> <b>Weight Bearing</b> <input type="checkbox"/> <b>Without Contrast</b> <input type="checkbox"/> <b>With Contrast</b>  <b>Head and Neck</b> <input type="checkbox"/> Brain <input type="checkbox"/> Brain w/SWI <input type="checkbox"/> IAC's <input type="checkbox"/> Pituitary-Sella <input type="checkbox"/> Orbits <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Other: _____  <table border="0"> <tr> <td><b>L</b></td> <td><b>R</b></td> <td><b>Extremities</b></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Shoulder</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Brachial Plexus</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Humerus</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Elbow</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Forearm</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Wrist</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hand: _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hip</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Knee</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Tib/Fib (lower leg)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Ankle</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hind Foot</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Fore Foot</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Femur</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other: _____</td> </tr> </table> <b>Spine</b> <input type="checkbox"/> Cervical <input type="checkbox"/> Pelvis <input type="checkbox"/> Thoracic <input type="checkbox"/> Sacrum <input type="checkbox"/> Lumbar  <input type="checkbox"/> <b>MRI ARTHROGRAM</b> Specify: _____  <input type="checkbox"/> <b>MRA</b> <input type="checkbox"/> Head <input type="checkbox"/> Renal <input type="checkbox"/> Neck <input type="checkbox"/> Mesenteric	<b>L</b>	<b>R</b>	<b>Extremities</b>	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Brachial Plexus	<input type="checkbox"/>	<input type="checkbox"/>	Humerus	<input type="checkbox"/>	<input type="checkbox"/>	Elbow	<input type="checkbox"/>	<input type="checkbox"/>	Forearm	<input type="checkbox"/>	<input type="checkbox"/>	Wrist	<input type="checkbox"/>	<input type="checkbox"/>	Hand: _____	<input type="checkbox"/>	<input type="checkbox"/>	Hip	<input type="checkbox"/>	<input type="checkbox"/>	Knee	<input type="checkbox"/>	<input type="checkbox"/>	Tib/Fib (lower leg)	<input type="checkbox"/>	<input type="checkbox"/>	Ankle	<input type="checkbox"/>	<input type="checkbox"/>	Hind Foot	<input type="checkbox"/>	<input type="checkbox"/>	Fore Foot	<input type="checkbox"/>	<input type="checkbox"/>	Femur	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/> <b>CT</b> <input type="checkbox"/> <b>CTA</b> <input type="checkbox"/> <b>CT ARTHROGRAM</b> <input type="checkbox"/> Without Contrast <input type="checkbox"/> With Contrast <input type="checkbox"/> With & Without Contrast <input type="checkbox"/> Oral Contrast  <i>* All Contrast Is Per Radiologist Protocol</i>  <b>Head and Neck</b> <input type="checkbox"/> Brain <input type="checkbox"/> IAC's/Orbits/Sella <input type="checkbox"/> Maxillofacial <input type="checkbox"/> Sinus <input type="checkbox"/> Soft Tissue Neck  <b>Chest</b> <input type="checkbox"/> Chest <input type="checkbox"/> Heart (Calcium Scoring) <input type="checkbox"/> Lung Cancer Screening  <b>Abdomen and Pelvis</b> <input type="checkbox"/> Abdomen <input type="checkbox"/> Abdomen and Pelvis <input type="checkbox"/> Pelvis  <b>Spine</b> <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar  <b>Extremities</b> <input type="checkbox"/> Lower Ext: _____ Specify Extremity <input type="checkbox"/> Upper Ext: _____ Specify Extremity <input type="checkbox"/> Lower Ext Runoff <input type="checkbox"/> Upper Ext Runoff	<input type="checkbox"/> Abdominal Limited _____ <input type="checkbox"/> Abdominal Complete <input type="checkbox"/> Aorta <input type="checkbox"/> Aorta Doppler <input type="checkbox"/> Arterial Doppler Lower Extremity: <input type="checkbox"/> RT. <input type="checkbox"/> LT. <input type="checkbox"/> BILAT. <input type="checkbox"/> Arterial Doppler Upper Extremity: <input type="checkbox"/> RT. <input type="checkbox"/> LT. <input type="checkbox"/> BILAT. <input type="checkbox"/> Carotid Doppler <input type="checkbox"/> Bladder <input type="checkbox"/> Obstetrical < 14 Weeks <input type="checkbox"/> Obstetrical > 14 Weeks <input type="checkbox"/> Biophysical Profile <input type="checkbox"/> Pelvic <input type="checkbox"/> Pelvic/Transvaginal <input type="checkbox"/> Pelvic Doppler (Ovaries) for mass or torsion <input type="checkbox"/> Renal <input type="checkbox"/> Renal Doppler <input type="checkbox"/> Soft Tissue: _____ <input type="checkbox"/> Thyroid/Head/Neck <input type="checkbox"/> Testicular <input type="checkbox"/> Testicular Doppler for mass or torsion <input type="checkbox"/> Venous Doppler Lower Extremity: <input type="checkbox"/> RT. <input type="checkbox"/> LT. <input type="checkbox"/> BILAT. <input type="checkbox"/> Venous Doppler Upper Extremity: <input type="checkbox"/> RT. <input type="checkbox"/> LT. <input type="checkbox"/> BILAT. <input type="checkbox"/> Other: _____  <div style="background-color: #cccccc; text-align: center; padding: 5px;"><b>TBI TESTING</b></div> <input type="checkbox"/> <b>TBI GENERAL SCREENING</b> <input type="checkbox"/> <b>VNG</b> <input type="checkbox"/> <b>DTI (performed with MRI)</b>	<b>Spine</b> <input type="checkbox"/> Cervical <input type="checkbox"/> 2V or 3V <input type="checkbox"/> Complete <input type="checkbox"/> Complete+Flex/Ext <input type="checkbox"/> Thoracic 2V <input type="checkbox"/> Lumbar <input type="checkbox"/> 2V or 3V <input type="checkbox"/> Complete <input type="checkbox"/> Complete+Flex/Ext <input type="checkbox"/> Sacrum/Coccyx <input type="checkbox"/> Thoracolumbar <input type="checkbox"/> Other: _____  <table border="0"> <tr> <td><b>Skeletal</b></td> <td><b>L</b></td> <td><b>R</b></td> </tr> <tr> <td><input type="checkbox"/> Finger</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Hand</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input 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type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Sternum</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Pelvis</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other: _____</td> <td></td> <td></td> </tr> </table> <b>Chest and Abdomen</b> <input type="checkbox"/> 2-View Chest <input type="checkbox"/> 1-View Abdomen (KUB) <input type="checkbox"/> Abdomen Complete <input type="checkbox"/> Abdomen Series (PA Chest + Upright/Supine Abdomen) <input type="checkbox"/> Other: _____  <input type="checkbox"/> <b>VMA</b> <input type="checkbox"/> C-Spine <input type="checkbox"/> L-Spine <input type="checkbox"/> C&L Spine	<b>Skeletal</b>	<b>L</b>	<b>R</b>	<input type="checkbox"/> Finger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Wrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Forearm	<input 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**PLEASE ARRIVE** 30 minutes prior to your scheduled time. If for any reason you need to reschedule or cancel your appointment, you must call as soon as possible.



**PATIENT PREPARATION:**  
You may eat normally and take any medication you regularly take. Before Your Exam, you'll be asked to remove your eyeglasses, watch, jewelry, credit cards, dentures, hearing aids and any other metallic objects you are carrying.

**KILLEEN**  
3800 South W.S. Young Ste #302  
Killeen, TX 76542

**CEDAR PARK**  
715 Discovery Blvd. Ste #102  
Cedar Park, TX 78613

**PARMER LANE**  
1212 West Parmer Ln Ste J  
Austin, TX 78727

**ROLLINGWOOD**  
2745 Bee Caves Rd Ste #102  
Rollingwood, TX 78746

**JAMES CASEY ST**  
4316 James Casey St Ste F-110  
Austin, TX 78745

**ONION CREEK**  
701 E. 1626  
Austin, TX 78652

**BASTROP**  
3101 Hwy 71 East Ste #108  
Bastrop, TX 78602

**MARBLE FALLS**  
1005 Falls Pkwy, Ste #103  
Marble Falls, TX 78654

**PRECAUTIONS:** It is **VERY IMPORTANT** to tell the technician if you have, or think you have anything metallic in your body, which could be attracted by the magnet. These objects include metal plates, surgical clips, joint or bone pins, bullet fragments, shrapnel or BB shots. Please bring previous X-ray, CAT scan's and MRI's concerning today's test. **Notify the technician if you are pregnant or think you might be pregnant.**



# LONGHORN IMAGING

## ACCEPTED INSURANCE

Absolute Solutions  
 Aetna  
 Aetna Medicare Plan  
 All Savers  
 Altrua Health Share  
 AmeriPlan  
 Ancillary Care Services  
 Ascension BCBS (Smart Health)  
 BCBS  
 BCBS CHIP and STAR  
 BCBS HMO Blue  
 Beech Street  
 Bright Healthcare  
 Cigna  
 Coast2Coast Diagnostics  
 Concentra  
 CoreChoice  
 Carvel  
 Cypress Care  
 DOL  
 Employer's Choice Network  
 FedMed  
 First Health  
 Freedom Life Insurance  
 Galaxy Health Network  
 GEHA United Healthcare Choice Plus  
 GEHA United Healthcare Options PPO

GEHA United Healthcare Aetna  
 GENEX Services, Inc.  
 Green Imaging  
 Health Partners Cigna  
 Humana  
 IMO, Inc.  
 Imperial Insurance Company  
 Johnson & Associates, Inc.  
 Key Health Management  
 Med-Eval (Injury Care Services)  
 Med Chex  
 Medicaid  
 Medicare  
 Med Options  
 Med Solutions  
 MedStar Funding  
 Meritain Health  
 Midwest Medical HPO  
 MTI (MedComp USA)  
 MultiPlan  
 NPN  
 Occu Comp  
 One Call Medical  
 Optum Workers Comp  
 Oscar  
 PHCS (see MultiPlan)  
 Physicians Mutual Insurance

Preferred Care  
 Prime Health Services, Inc.  
 Provider Select, Inc.  
 Sendero Health Plans  
 Secure Horizons (UHC)  
 Sedgwick  
 Solidarity Healthshare  
 Superior Health Plan  
 Tech Health  
 Three Rivers  
 TLC Advantage  
 TriCare  
 UMR  
 United American  
 United Healthcare AARP  
 United Healthcare  
 United Healthcare Choice (Golden Rule)  
 United Healthcare One (Golden Rule)  
 United World Life  
 USA MCO  
 USA MCO Medicare Sup  
 USA MCO Workers Comp  
 US Imaging, Inc.  
 Well States Healthcare  
 Wellmed  
 Wellcare

*Insurance List Updated October 2022*

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