*Please Select Facility*

# LONGHORN IMAGING

*11 convenient Austin locations. Please see back of page for map and complete listing.*

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

Patient Name _____ D.O.B. _____ Phone # _____ Gender _____

Insurance _____ Insurance ID# _____

(PRINT) Referring Dr: _____ Referring Office Contact: _____

Please Print Legibly

*Referring Office*

Phone: _____ Fax: _____ Email: _____

Please Print Legibly

*Referring Physician Signature:*

X _____

May modify exam at radiologists discretion if clinically indicated.

*Ordered Date:* _____

X _____

Scan as ordered.

☐ **STAT EXAM** **medically necessary*

☐ **ASAP EXAM** **will be treated as STAT unless superceded*

DIAGNOSIS OR ICD-10 CODE(S) _____

REASON FOR EXAM/NOTES _____

**STAT/ASAP RESULTS** *(How would you like to receive?)*

☐ **CALL** **you MUST provide a cell number or results will be faxed* _____

☐ **FAX** _____

**PLEASE FAX SIGNED ORDERS, DEMOGRAPHICS, INSURANCE AND CLINICALS**

## MRI

☐ **1.5T MRI**
☐ **Weight Bearing**
☐ **Without Contrast**
☐ **With Contrast**

*If no contrast boxes are marked, the exam will be considered PRN/at the discretion of the radiologist.*

### Head and Neck

☐ Brain
☐ Brain w/SWI
☐ IAC's
☐ Pituitary-Sella
☐ Orbits
☐ Soft Tissue Neck
☐ Other:_____

| L | R | Extremities |
|---|---|---|
| ☐ | ☐ | Shoulder |
| ☐ | ☐ | Brachial Plexus |
| ☐ | ☐ | Humerus |
| ☐ | ☐ | Elbow |
| ☐ | ☐ | Forearm |
| ☐ | ☐ | Wrist |
| ☐ | ☐ | Hand:_____ |
| ☐ | ☐ | Hip |
| ☐ | ☐ | Knee |
| ☐ | ☐ | Tib/Fib (lower leg) |
| ☐ | ☐ | Ankle |
| ☐ | ☐ | Hind Foot |
| ☐ | ☐ | Fore Foot |
| ☐ | ☐ | Femur |
| ☐ | ☐ | Other:_____ |

### Spine

☐ Cervical ☐ Pelvis
☐ Thoracic ☐ Sacrum
☐ Lumbar

☐ **MRI ARTHROGRAM**

Specify:_____

☐ **MRA**

☐ Head ☐ Renal
☐ Neck ☐ Mesenteric
☐ Lower Extremity Runoff

## CT

☐ **CT** ☐ **CTA**
☐ **CT ARTHROGRAM**

☐ Without Contrast
☐ With Contrast
☐ With & Without Contrast
☐ Oral Contrast

** All Contrast Is Per Radiologist Protocol*
*If no contrast boxes are marked, the exam will be considered PRN/at the discretion of the radiologist.*

### Head and Neck

☐ Brain
☐ IAC's/Orbits/Sella
☐ Maxillofacial
☐ Sinus
☐ Soft Tissue Neck

### Chest

☐ Chest
☐ Heart (Calcium Scoring)
☐ Lung Cancer Screening

### Abdomen and Pelvis

☐ Abdomen
☐ Abdomen and Pelvis
☐ Pelvis

### Spine

☐ Cervical
☐ Thoracic
☐ Lumbar

### Extremities ☐ RT. ☐ LT.

☐ Lower Ext: _____Specify Extremity
☐ Upper Ext: _____Specify Extremity
☐ Lower Ext Runoff
☐ Upper Ext Runoff

### Bone Density

☑ CT Bone Density (Spine Only)

## ULTRASOUND

☐ Abdominal Limited_____
☐ Abdominal Complete
☐ Aorta
☐ Aorta Doppler
☐ Arterial Doppler Lower Extremity:
☐ RT. ☐ LT. ☐ BILAT.
☐ Arterial Doppler Upper Extremity:
☐ RT. ☐ LT. ☐ BILAT.
☐ Carotid Doppler
☐ Bladder
☐ Obstetrical < 14 Weeks with transvaginal if needed
☐ Obstetrical > 14 Weeks
☐ Biophysical Profile
☐ Pelvic
☐ Pelvic and Transvaginal
☐ Transvaginal Only
☐ Renal
☐ Renal Doppler
☐ Soft Tissue:_____
☐ Thyroid/Head/Neck
☐ Testicular
☐ Testicular Doppler for mass or torsion
☐ Venous Doppler Lower Extremity:
☐ RT. ☐ LT. ☐ BILAT.
☐ Venous Doppler Upper Extremity:
☐ RT. ☐ LT. ☐ BILAT.
☐ Other:_____

## TBI TESTING

☐ **TBI GENERAL SCREENING**
☐ **VNG**
☐ **DTI (performed with MRI)**

## X-RAY

### Spine

☐ Cervical ☐ 2V or 3V ☐ Complete ☐ Complete+Flex/Ext
☐ Thoracic 2V
☐ Lumbar ☐ 2V or 3V ☐ Complete ☐ Complete+Flex/Ext
☐ Sacrum/Coccyx
☐ Thoracolumbar
☐ Other:_____

| Skeletal | L | R |
|---|---|---|
| ☐ Finger | ☐ | ☐ |
| ☐ Hand | ☐ | ☐ |
| ☐ Wrist | ☐ | ☐ |
| ☐ Forearm | ☐ | ☐ |
| ☐ Elbow | ☐ | ☐ |
| ☐ Humerus | ☐ | ☐ |
| ☐ Shoulder | ☐ | ☐ |
| ☐ A-C Joints | ☐ | ☐ |
| ☐ Clavicle | ☐ | ☐ |
| ☐ Ribs | ☐ | ☐ |
| ☐ Hip | ☐ | ☐ |
| ☐ Femur | ☐ | ☐ |
| ☐ Knee | ☐ | ☐ |
| ☐ Tib/Fib | ☐ | ☐ |
| ☐ Ankle | ☐ | ☐ |
| ☐ Heel | ☐ | ☐ |
| ☐ Foot | ☐ | ☐ |
| ☐ Toe | ☐ | ☐ |
| ☐ SI Joints | ☐ | ☐ |

☐ Sternum
☐ Pelvis
☐ Other_____

### Chest and Abdomen

☐ 2-View Chest
☐ 1-View Abdomen (KUB)
☐ Abdomen Complete
☐ Abdomen Series (PA Chest + Upright/Supine Abdomen)
☐ Other_____

☐ **VMA** ☐ C-Spine ☐ L-Spine ☐ C&L Spine

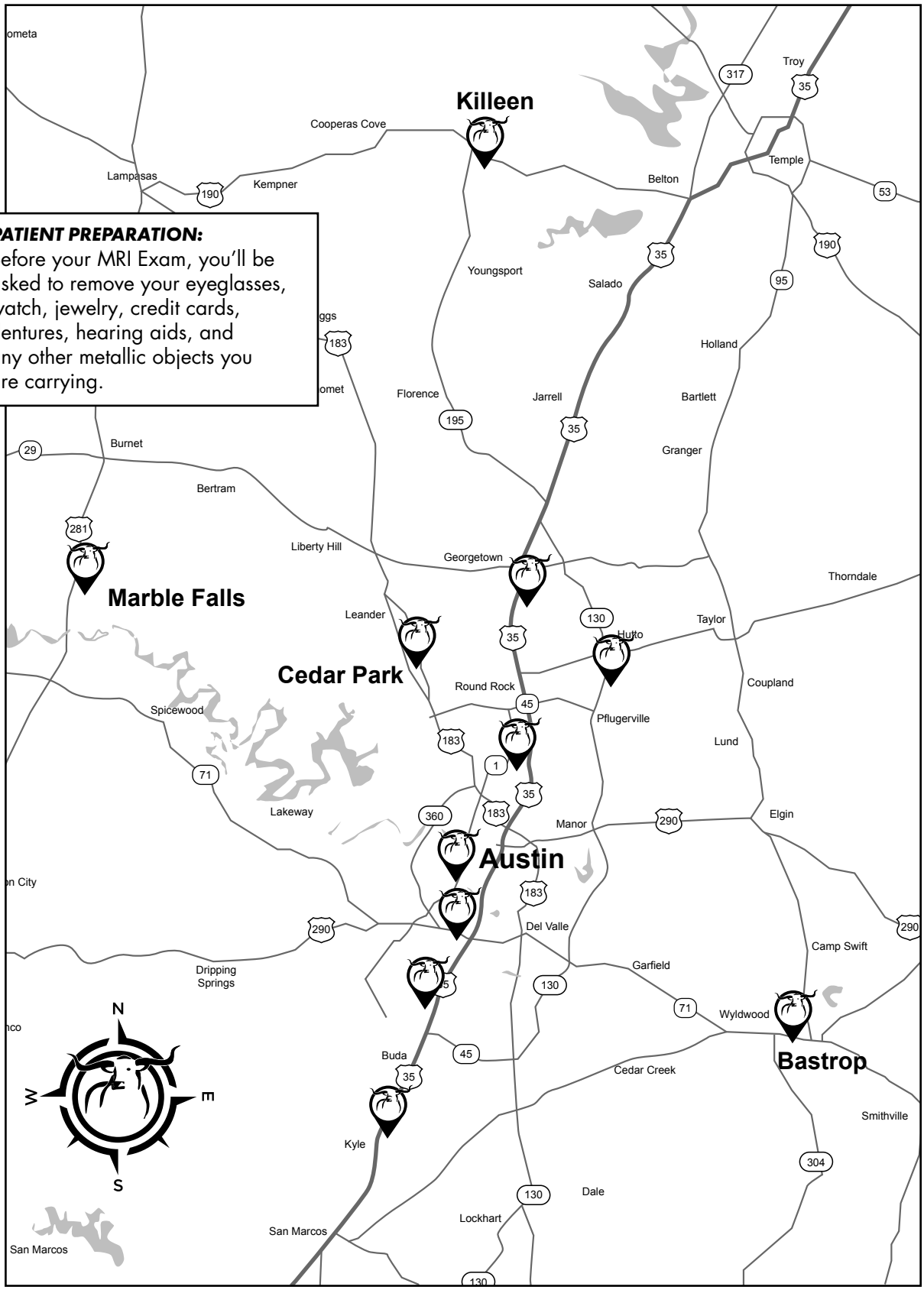


REV. 196564-92320.2

# LONGHORN IMAGING

**Phone: 512-444-8900** **Fax: 512-444-7244**

***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:***
Before your MRI 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

**HUTTO**
201 East Wilco Hwy Ste 103
Hutto, TX 78634

**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

**GEORGETOWN**
1502 Blue Ridge Dr, Ste #103
Georgetown, TX 78626

**KYLE**
135 Bunton Creek Rd Ste 101
Kyle, TX 78640

***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 scans and MRI's concerning today's test. ***Notify the technician if you are pregnant or think you might be pregnant.***