



Please Select Facility

LONGHORN IMAGING



☐ HUEBNER

☐ STONE OAK

*** More San Antonio Locations Coming Soon ***

FAX: 210-855-9096

SCHEDULING: 210-807-4513

EMAIL: referrals@longhornimaging.com

Patient Name

D.O.B.

Phone #

Gender

Insurance

Insurance ID#

(PRINT) Referring Dr: _____

Please Print Legibly

Referring Office Contact: _____

Referring Office

Phone: _____ Fax: _____ Email: _____

Please Print Legibly

Referring Physician Signature: _____

Ordered Date: _____

☐ **STAT EXAM** *medically necessary

X

X

☐ **ASAP EXAM** *will be treated as STAT unless superceded

May modify exam at radiologists discretion if clinically indicated.

Scan as ordered.

STAT/ASAP RESULTS

(How would you like to receive?)

DIAGNOSIS

OR ICD-10

CODE(S)

REASON

FOR

EXAM/NOTES

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

☐ **FAX**

☐ **PLEASE COMPARE TO PREVIOUS**

PLEASE FAX SIGNED ORDERS, DEMOGRAPHICS, INSURANCE AND CLINICALS

MRI

☐ **3T MRI**

☐ **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

- | | | |
|--------------------------|--------------------------|---------------------|
| <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: _____ |

Spine

- | | |
|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Cervical | <input type="checkbox"/> Pelvis |
| <input type="checkbox"/> Thoracic | <input type="checkbox"/> Sacrum |
| <input type="checkbox"/> Lumbar | |

Pelvis

- ☐ Male Pelvis/Prostate

MRA

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Renal |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Mesenteric |
| <input type="checkbox"/> Lower Extremity Runoff | |

CT

☐ **CTA**

- ☐ 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

- ☐ Lower Ext: ☐ L ☐ R
Specify Extremity
☐ Upper Ext: ☐ L ☐ R
Specify Extremity

- ☐ Lower Ext Runoff
☐ Upper Ext Runoff

Bone Density

- ☐ CT Bone Density (Spine Only)

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 |
|-------------------------------------|--------------------------|--------------------------|
| <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 type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Elbow | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Humerus | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> A-C Joints | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Clavicle | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Ribs | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hip | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Femur | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Knee | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Tib/Fib | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Ankle | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Heel | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Foot | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Toe | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> SI Joints | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Sternum | | |
| <input type="checkbox"/> Pelvis | | |
| <input type="checkbox"/> Other | | |

Chest and Abdomen

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



LONGHORN IMAGING

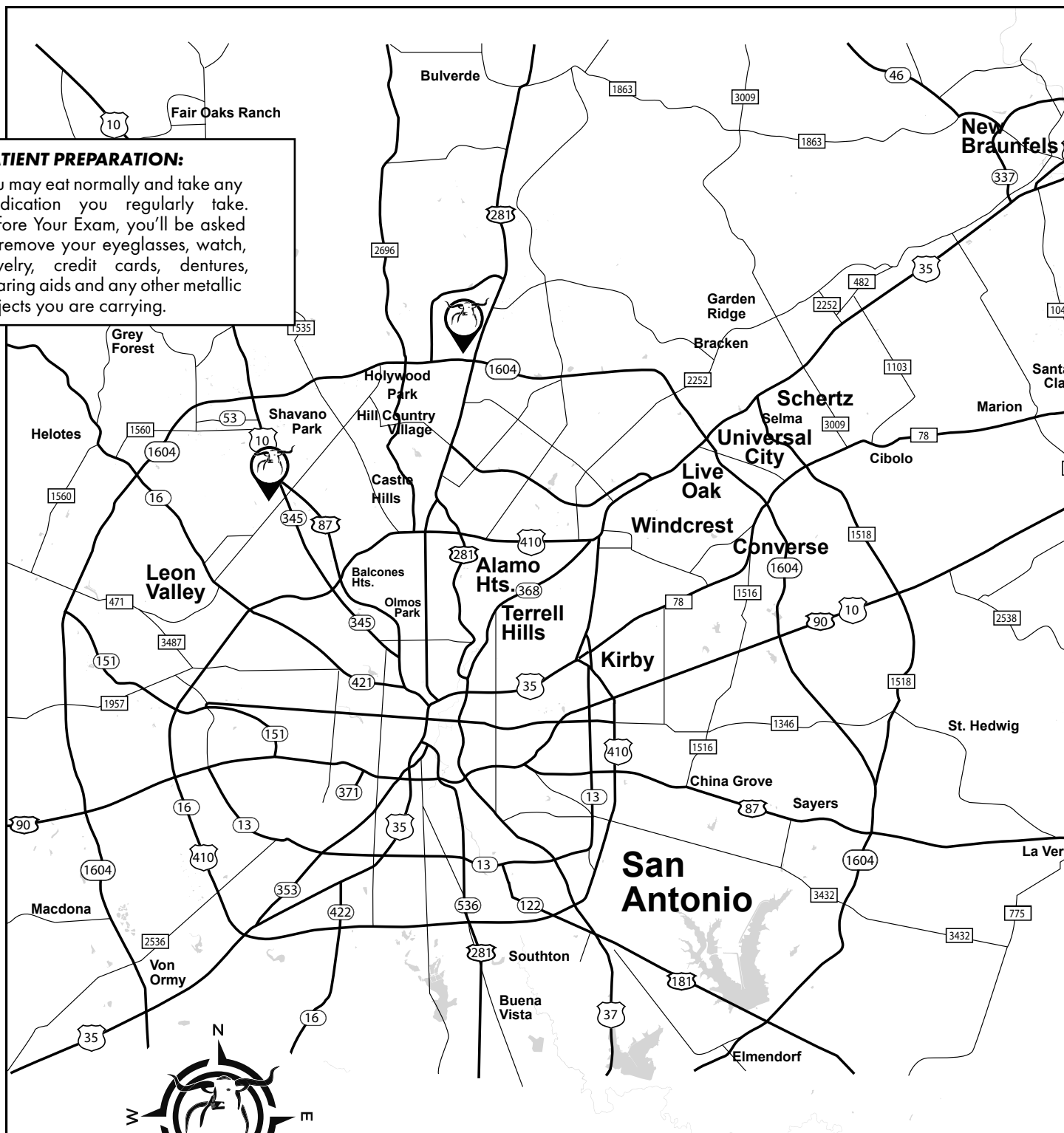
Phone: 210-807-4513

Fax: 210-855-9096

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.



Huebner

10103 Huebner Rd, Ste #102
San Antonio, TX 78240

Stone Oak

18626 Hardy Oak Blvd, Ste #100
San Antonio, TX 78258

11 locations in and around Austin

Check out the website for more details
www.longhornimaging.com

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.**