



LONGHORN IMAGING



Please Select Facility

* 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: _____ Ordered Date: _____

X May modify exam at radiologists discretion if clinically indicated. **X** Scan as ordered.

DIAGNOSIS OR ICD-10 CODE(S) _____

REASON FOR EXAM/NOTES _____

- STAT EXAM** *medically necessary
- ASAP EXAM** *will be treated as STAT unless superceded
- STAT/ASAP RESULTS** (How would you like to receive?)
- CALL** *you MUST provide a call number or results will be faxed
- FAX**
- PLEASE COMPARE TO PREVIOUS**

PLEASE FAX SIGNED ORDERS, DEMOGRAPHICS, INSURANCE AND CLINICALS

MRI	CT	ULTRASOUND	X-RAY																																																																																																																					
<input type="checkbox"/> 1.5T MRI <input type="checkbox"/> Weight Bearing <input type="checkbox"/> Without Contrast <input type="checkbox"/> With Contrast <small>If no contrast boxes are marked, the exam will be considered PRN/at the discretion of the radiologist.</small> Head and Neck <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>L</td> <td>R</td> <td>Extremities</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> 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type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other: _____</td> </tr> </table> Spine <input type="checkbox"/> Cervical <input type="checkbox"/> Pelvis <input type="checkbox"/> Thoracic <input type="checkbox"/> Sacrum <input type="checkbox"/> Lumbar <input type="checkbox"/> MRI ARTHROGRAM Specify: _____ <input type="checkbox"/> MRA <input type="checkbox"/> Head <input type="checkbox"/> Renal <input type="checkbox"/> Neck <input type="checkbox"/> Mesenteric <input type="checkbox"/> Lower Extremity Runoff	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: _____	<input type="checkbox"/> CT <input type="checkbox"/> CTA <input type="checkbox"/> CT ARTHROGRAM <input type="checkbox"/> Without Contrast <input type="checkbox"/> With Contrast <input type="checkbox"/> With & Without Contrast <input type="checkbox"/> Oral Contrast <small>* All Contrast Is Per Radiologist Protocol If no contrast boxes are marked, the exam will be considered PRN/at the discretion of the radiologist.</small> Head and Neck <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 Chest <input type="checkbox"/> Chest <input type="checkbox"/> Heart (Calcium Scoring) <input type="checkbox"/> Lung Cancer Screening Abdomen and Pelvis <input type="checkbox"/> Abdomen <input type="checkbox"/> Abdomen and Pelvis <input type="checkbox"/> Pelvis Spine <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar Extremities <input type="checkbox"/> RT. <input type="checkbox"/> LT. <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 Bone Density <input type="checkbox"/> CT Bone Density (Spine Only)	<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 with transvaginal if needed <input type="checkbox"/> Obstetrical > 14 Weeks <input type="checkbox"/> Biophysical Profile <input type="checkbox"/> Pelvic <input type="checkbox"/> Pelvic and Transvaginal <input type="checkbox"/> Transvaginal Only <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: black; color: white; text-align: center; padding: 5px;">TBI TESTING</div> <input type="checkbox"/> TBI GENERAL SCREENING <input type="checkbox"/> VNG <input type="checkbox"/> DTI (performed with MRI)	Spine <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>Skeletal</td> <td>L</td> <td>R</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 type="checkbox"/> Wrist</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Forearm</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Elbow</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Humerus</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> A-C Joints</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Clavicle</td> <td><input 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FULL BODY IMAGING - Early Cancer Detection in Under 2 Hours

- Longhorn 180**
- Includes:
 - MRI Brain
 - MRI Soft Tissue Neck
 - MRI Abdomen
 - MRI Female Pelvis or Male Pelvis w/Prostate

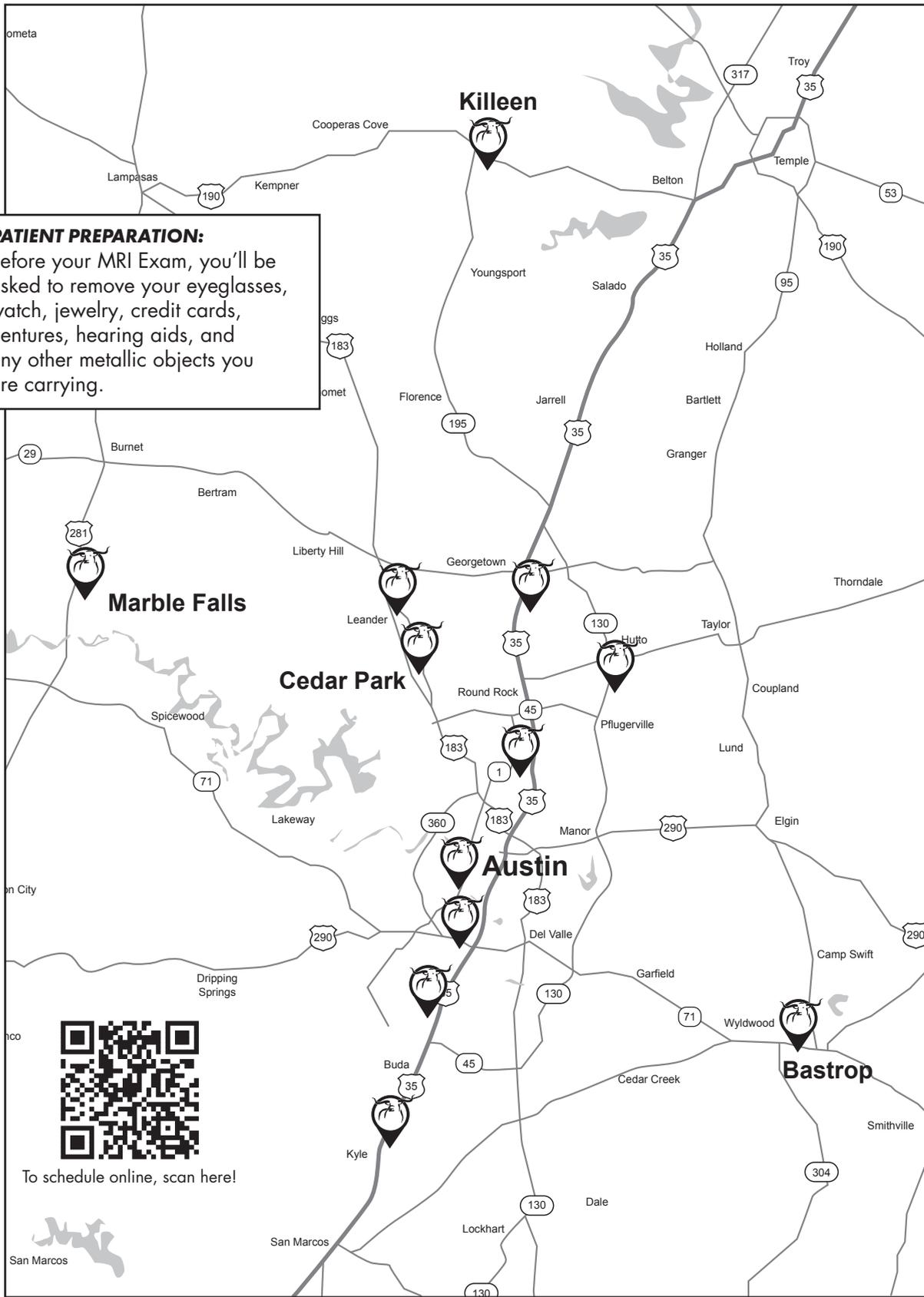
- Longhorn 360**
- Includes:
 - MRI Brain
 - MRI Soft Tissue Neck
 - MRI Entire Spine
 - MRI Abdomen
 - MRI Female Pelvis or Male Pelvis w/Prostate

- Longhorn 360+**
- Includes:
 - MRI Brain
 - MRA Head
 - MRI Soft Tissue Neck
 - MRA Neck
 - MRI Entire Spine
 - MRI Abdomen
 - MRI Female Pelvis or Male Pelvis w/Prostate
 - CT Low Dose Lung Screening
 - CT Calcium Score

- Add Ons:**
- NeuroQuant Seizure
- NeuroQuant MS
- NeuroQuant MS Plus
- NeuroQuant Alzheimer's
- NeuroQuant Dementia
- NeuroQuant Alzheimer's + Dementia
- NeuroQuant Alzheimer's + Dementia + Seizure
- NeuroQuant Prostate

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.



To schedule online, scan here!

LEANDER

780 W Broade Street
 Leander, TX 76541

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.*