New Hope
Imaging Services

Facility Locations on Reverse Side

RADIOLOGICAL Rx

Please give this form to patient & fax to:

Fax 1 (855) 743-8722

Phone (855) 7-GET SCAN

APPOINTMENT DATE	LOCATION	TIME

REFERRING PHYSICIAN (Last, First, Suffix REQUIRED)		REF PHYS SIGNATURE
REF PHYS PHONE	FAX	EMAIL
CLINICAL INDICATION FOR EXAM (Dx REQUIRED)		DATE

MRI (Advise of ANY ELECTRONIC or METAL implants)

Glomerular Filtration Rate (GFR): ❑ Oral Sedation ❑ I/V

- ❑ Head/Brain ❑ W/O ❑ W/Contrast
- ❑ Circle of Willis ❑ W/O ❑ W/Contrast
- ❑ Orbits ❑ W/O ❑ W/Contrast
- ❑ Sinuses ❑ W/O ❑ W/Contrast
- ❑ TMJ ❑ W/O ❑ W/Contrast
- ❑ IAC ❑ W/O ❑ W/Contrast
- ❑ Neck (Soft Tissue) ❑ W/O ❑ W/Contrast
- ❑ Brachial Plexus ❑ W/O ❑ W/Contrast
- ❑ Breast ❑ W/O ❑ W/Contrast
  - ❑ Right ❑ Left ❑ Both
- ❑ Chest ❑ W/O ❑ W/Contrast
- ❑ Abdomen ❑ W/O ❑ W/Contrast
- ❑ Cervical Spine ❑ W/O ❑ W/Contrast
- ❑ Thoracic Spine ❑ W/O ❑ W/Contrast
- ❑ Lumbar Spine ❑ W/O ❑ W/Contrast
- ❑ Abdomen ❑ W/O ❑ W/Contrast
- ❑ Pelvic ❑ W/O ❑ W/Contrast
- ❑ MRCP ❑ W/O ❑ W/Contrast
  (Cholangio Pancreatography)
- ❑ Shoulder ❑ W/O ❑ W/Contrast
  - ❑ Right ❑ Left ❑ Both
- ❑ Rib ❑ W/O ❑ W/Contrast
  - ❑ Right ❑ Left ❑ Both
- ❑ Elbow ❑ W/O ❑ W/Contrast
  - ❑ Right ❑ Left ❑ Both
- ❑ Forearm ❑ W/O ❑ W/Contrast
  - ❑ Right ❑ Left ❑ Both
- ❑ Wrist ❑ W/O ❑ W/Contrast
  - ❑ Right ❑ Left ❑ Both
- ❑ Hand ❑ W/O ❑ W/Contrast
  - ❑ Right ❑ Left ❑ Both
- ❑ Fingers: ____________ ❑ W/O ❑ W/Contrast
- ❑ Hip ❑ W/O ❑ W/Contrast
  - ❑ Right ❑ Left ❑ Both
- ❑ Knee ❑ W/O ❑ W/Contrast
  - ❑ Right ❑ Left ❑ Both
- ❑ Lower Leg ❑ W/O ❑ W/Contrast
  - ❑ Right ❑ Left ❑ Both
- ❑ Ankle ❑ W/O ❑ W/Contrast
  - ❑ Right ❑ Left ❑ Both
- ❑ Foot ❑ W/O ❑ W/Contrast
  - ❑ Right ❑ Left ❑ Both
- ❑ MR Angiogram
  - ❑ Brain ❑ Neck ❑ Carotid
- ❑ Other: ____________ ❑ W/O ❑ W/Contrast

CT SCAN

Glomerular Filtration Rate (GFR): ❑ Oral Sedation ❑ I/V

- ❑ Sinus ❑ W/O ❑ W/Contrast
- ❑ Nose ❑ W/O ❑ W/Contrast
- ❑ Head ❑ W/O ❑ W/Contrast
- ❑ Neck (Soft Tissue) ❑ W/O ❑ W/Contrast
- ❑ Cervical Spine ❑ W/O ❑ W/Contrast
- ❑ Thoracic Spine ❑ W/O ❑ W/Contrast
- ❑ Lumbar Spine ❑ W/O ❑ W/Contrast
- ❑ Chest ❑ W/O ❑ W/Contrast
- ❑ Abdomen ❑ W/O ❑ W/Contrast
- ❑ Liver ❑ W/O ❑ W/Contrast
- ❑ Pelvis ❑ W/O ❑ W/Contrast
- ❑ Knee ❑ W/O ❑ W/Contrast
- ❑ Ankles ❑ W/O ❑ W/Contrast
- ❑ HRCT (Lungs)
- ❑ Other: ____________ ❑ W/O ❑ W/Contrast

X-RAY

KUB ❑

- ❑ Skull
- ❑ Mandible
- ❑ Mastoid
- ❑ Facial Bones
- ❑ Sinuses
- ❑ Neck – Soft Tissue

EXTREMITIES (Write Body Part)

- ❑ ____________ ❑ R ❑ L ❑ Both
- ❑ ____________ ❑ R ❑ L ❑ Both
- ❑ Pelvis

CHEST

- ❑ Chest (1-View)
- ❑ Chest (2-View)
- ❑ Ribs ❑ R ❑ L ❑ Both
- ❑ Sternum

SPINE

- ❑ Cervical Spine
  - ❑ Neutral ❑ Flexion & Extension ❑ Both
- ❑ Thoracic Spine
  - ❑ Neutral ❑ Flexion & Extension ❑ Both
- ❑ Lumbar Spine
  - ❑ Neutral ❑ Flexion & Extension ❑ Both
- ❑ Sacrum
- ❑ Coccyx

REQUIRED

PATIENT NAME (Last, First)		DATE OF BIRTH / /
HOME PHONE	CELL	EMAIL

EMPLOYER (WC Only)	ADDRESS	WORK PHONE

❑ WORKERS COMP	ATTORNEY	PHONE	EMPLOYER
❑ PERSONAL INJURY	ATTORNEY	PHONE	DATE OF INJURY / /
❑ INSURANCE	PROVIDER	PHONE	CLAIM #

❑ BILL TO OTHER

❑ ADDITIONAL NOTES:

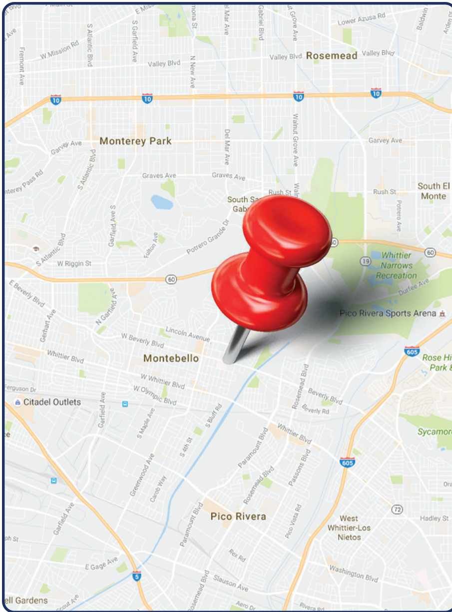
❑ STAT SERVICE REQUESTED – CALL #

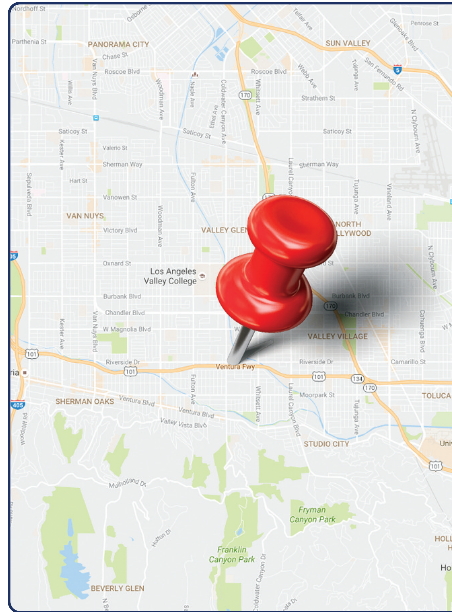
PREPARING FOR YOUR EXAMINATION

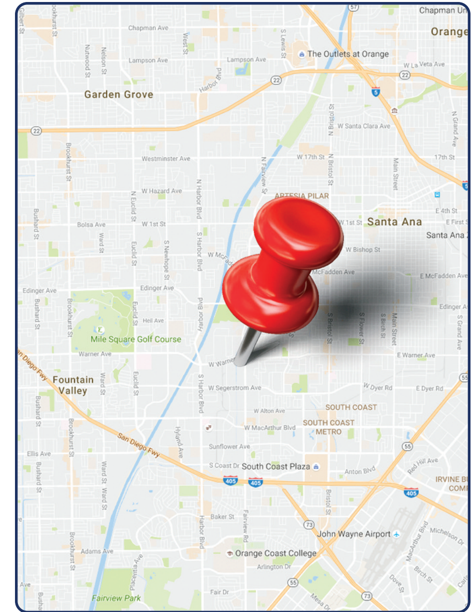
1. Please plan to arrive 15 minutes before your scheduled appointment time to sign-in.
2. Please bring your insurance or Medicare card with you.
3. Please remove ALL METALLIC ITEMS, including earrings, jewelry, watches, hairclips, etc.
4. You CANNOT BE SCANNED if you have a pacemaker, intra-cranial aneurysm clips, transcutaneous nerve stimulators or metal fragments in your body or eyes.
5. You may eat and drink as usual on the day of your exam unless notified otherwise.
6. Wear comfortable, loose-fitting clothing without metal zippers, snaps or trim and please leave valuables at home.
7. If you have any other questions or concerns about your procedure please call our central scheduling number below.

PREPARACIÓN PARA EL EXAMEN

1. Por favor haga planes para llegar 15 minutos antes de su cita para registrarse.
2. Por favor traiga su tarjeta de seguro o Medicare con usted.
3. Por favor, elimine todos los elementos metálicos, incluidos los pendientes, joyas, relojes, hairclips, etc.
4. Usted NO puede ser escaneado si tiene un marcapasos, clips de aneurisma intracraneales, estimuladores nerviosa transcutánea o fragmentos de metal en su cuerpo o los ojos.
5. Puede comer y beber de manera habitual en el día de su examen a menos que se notifique lo contrario.
6. Use ropa cómoda y holgada y sin cierres metálicos, broches clips y por favor deje objetos de valor en casa.
7. Si usted tiene alguna otra pregunta o preocupación acerca de su procedimiento, por favor llame a nuestro número telefonico de abajo.







❑ MONTEBELLO
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Montebello, CA 90640

❑ NORTH HOLLYWOOD
12840 Riverside Drive
North Hollywood, CA 91607

❑ SANTA ANA
2414 South Fairview St.
Santa Ana, CA 92704

New Hope
Imaging Services

Providing Exceptional Patient Service, Respect & Care

Phone (855) 743-8722
Se Habla Español