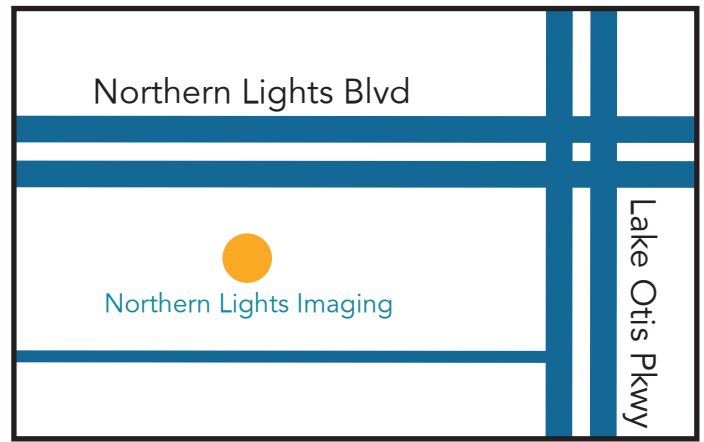




2110 E Northern Lights Blvd
Anchorage, AK 99508
P 907-644-2997
F 907-644-2998



PATIENT INSTRUCTIONS

EXAM-SPECIFIC INSTRUCTIONS

MRI – MRCP. ABDOMEN OR RENAL

- Nothing to eat or drink (including water) four hours prior to exam. (MRAs, ABDOMEN, LIVER, OR PELVIS MRIs)

ULTRASOUND - ABDOMEN

- Nothing to eat or drink (including water) after midnight the evening prior. Bring medication with you to take after exam.

ULTRASOUND - PELVIS/OB

- Drink 32 oz, of water one to two hours before and finish 30 minutes prior to the exam
- DO NOT urinate until after the exam

ULTRASOUND - RENAL

- Drink 24 oz, of water one to two hours before and finish 30 minutes prior to the exam
- DO NOT urinate until after the exam

SPECIAL PROCEDURES

- Driver needed for any spinal injections

GENERAL INSTRUCTIONS

- Patients will be asked to remove all metal from their person (i.e., earrings, watches, bobby pins, diabetic monitoring devices, etc.) and credit cards for all MRI exams.
- Lockers are provided. It's helpful if patient's clothing is comfortable (i.e., sweats) and doesn't include metal buttons, snaps or zippers.
- Please call 907.644.2997 prior to your scheduled appointment date to pre-register.



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TODAY'S DATE: ____ - ____ - ____

INSTRUCTIONS:

- Routine
- Urgent
- Call Report, patient wait

Phone _____

Fax _____

PATIENT'S LAST NAME	FIRST	MIDDLE INITIAL	PATIENT'S PHONE NUMBER	DATE OF BIRTH
ORDERING CLINICIAN		CLINICIAN SIGNATURE		Chart Notes & Demographic Info
SEND REPORT COPY TO				
REASON FOR STUDY		INSURANCE Group #/Identification #		

MRI

- CONTRAST AT RADIOLOGIST DISCRETION
- WITH IV CONTRAST
- ARTHROGRAM
- NO IV CONTRAST

- CERVICAL
- THORACIC
- LUMBAR
- METASTATIC SPINE SURVEY W/GAD

HEAD

- Brain
- Pituitary w/contrast
- IAC w/contrast
- TMJ
- Orbits w/gad
- MRA-Circle of Willis
- MRA-Carotids w/contrast

Other _____

- Shoulder
- Elbow
- Wrist
- Hand
- Finger
- Humerus
- Forearm

UPPER EXTREMITIES

- Right
- Left
- Right
- Left
- Right
- Left
- Right
- Left
- Right
- Left

LOWER EXTREMITIES

- Hip
- Knee
- Ankle
- Foot
- Femur
- Tib/Fib

- Right
- Left
- Right
- Left
- Right
- Left
- Right
- Left

BODY

- Abdomen
- Soft Tissue Neck
- Adrenals
- Liver
- Pelvis
- MRCP
- Kidneys
- Renal MRA w/gad
- Pancreas

CT SCAN

- CONTRAST AT RADIOLOGIST DISCRETION
- NO IV CONTRAST
- WITH IV CONTRAST

- Abdomen & Pelvis
- Abdomen
- C-Spine
- Chest
- Renal Stone Study
- T-Spine
- Chest High Resolution
- Pelvis
- L-Spine
- Head/Brain
- Maxillofacial
- Orbits
- Sinus
- Other _____
- Lung CA Screening, Low Dose
- IAC's/ Temporal Bone / Mastoids
- Neck, Soft Tissue
- ABD / Pelvic Angiogram (for AAA)
- PE Study
- ABD Aortogram & Lower Extremity Runoff
- CT IVP (urogram)
- 3 Phase Abdomen
- Carotids (aortic arch to Circle of Willis)
- Liver
- CTA Chest
- Kidney
- Pancreas

ULTRASOUND

- Echocardiogram
- Abdominal Limited (GB, Liver, Pancreas, Aorta, RT Kidney) (NPO for 8 hours)
- Abdominal Complete (ABD LTD+Spleen and LT Kidney) (NPO for 8 hours)
- Renal/Bladder (Full Bladder)
- Renal Artery Duplex
- Pelvic w/TV (Full Bladder)
- Testicular
- Musculoskeletal
- Thyroid
- Thyroid FNA
- Aorta Duplex
- Venous Duplex Leg: Right Left
- Venous Duplex Arm: Right Left
- Arterial Duplex Leg: Right Left
- Arterial Duplex Arm: Right Left
- Carotid
- OB, First Trimester w/TV
- OB, 2-3 Trimester Other

SPECIAL PROCEDURES

- Epidural* R L
- Nerve Root Block* Level _____
- Facet Injection* Level _____
- SI Joint*
- Joint Injection _____

*Driver needed for Patient

X-Ray

Spine	Flex & Ext.	Oblqs.	Upper Extremity	#Views	Right	Left	Lower Extremity	#Views	Right	Left	
<input type="checkbox"/> Cervical	<input type="checkbox"/>	<input type="checkbox"/>	Finger	_____	<input type="checkbox"/>	<input type="checkbox"/>	Toes	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Abdomen (KUB)
<input type="checkbox"/> Thoracic			Hand	_____	<input type="checkbox"/>	<input type="checkbox"/>	Foot	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Abdomen Flat/Upright
<input type="checkbox"/> Lumbar	<input type="checkbox"/>	<input type="checkbox"/>	Wrist	_____	<input type="checkbox"/>	<input type="checkbox"/>	Calcaneous	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Abdomen Series (w/Chest)
<input type="checkbox"/> Pelvis			Forearm	_____	<input type="checkbox"/>	<input type="checkbox"/>	Ankle	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Skull Series
<input type="checkbox"/> SI Joints			Elbow	_____	<input type="checkbox"/>	<input type="checkbox"/>	Tib-Fib	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sinus Series
<input type="checkbox"/> Sacrum/Coccyx			Humerus	_____	<input type="checkbox"/>	<input type="checkbox"/>	Knee	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Facial Bones
			Shoulder	_____	<input type="checkbox"/>	<input type="checkbox"/>	Femur	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Rib Series Right Left
			Clavicle	_____	<input type="checkbox"/>	<input type="checkbox"/>	Hip	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest 2V
											<input type="checkbox"/> Other _____