

3.0 Tesla MRI, the Ultimate in High-Definition MRI

| PATIENT INFORMATION | PHYSICIAN OFFICE INFORMATION |
|--|---|
| Patient's Last Name: _____ | Today's Date: _____ |
| First: _____ MI: _____ <input type="checkbox"/> M <input type="checkbox"/> F | Person Scheduling Appt.: _____ |
| SS#: _____ Date of Birth: _____ | Phone: _____ Fax: _____ |
| Height: _____ Weight: _____ | <input type="checkbox"/> Call patient to schedule appointment |
| Home Phone: _____ | <input type="checkbox"/> Contact person above with appointment time |
| Work: _____ Cell: _____ | Appointment Date: _____ Time: _____ |
| Insurance: _____ | Referring Doctor: _____ |
| Policy/Claim #: _____ Group #: _____ | |
| Authorization # (if applicable): _____ | |
| Employer: _____ | |

Doctor's SIGNATURE:

Required per HCFA policy #99-4.8

Please fax both sides of patient's insurance card with this request.

- HMO PPO/Private Workers' Compensation Auto (Med Pay) Medicare Medi-Cal Other _____

DIAGNOSIS & SYMPTOMS: _____

For contrast exams, **Creatinine** results within last 30 days are required for patients age 70+, or who have diabetes or kidney disease.
Please fax results with this request.

EXAM:

X-RAY Exam Requested: _____

MR Arthrogram: _____

MRI: Contrast Yes No If Needed

| | | | |
|---|--|----------------------------|----------------------------|
| <input type="checkbox"/> Brain (Routine) | <input type="checkbox"/> Shoulder | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Brain (Pituitary) | <input type="checkbox"/> Elbow | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Brain (I.A.C.) | <input type="checkbox"/> Wrist | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Brain (Stem/Post. Fossa) | <input type="checkbox"/> Hips | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Soft Tissue Neck (Mass) | <input type="checkbox"/> Knee | <input type="checkbox"/> R | <input type="checkbox"/> L |
| | <input type="checkbox"/> Ankle | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> C Spine | <input type="checkbox"/> Foot | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> T Spine | <input type="checkbox"/> Chest/Heart/Brachial Plexus | | |
| <input type="checkbox"/> L Spine | <input type="checkbox"/> Abdomen | | |
| <input type="checkbox"/> Sacrum/Coccyx | <input type="checkbox"/> Pelvis | | |
| <input type="checkbox"/> S.I. Joints | <input type="checkbox"/> Other: _____ | | |

MR ANGIOGRAPHY

| | |
|--------------------------------------|--|
| <input type="checkbox"/> Brain | <input type="checkbox"/> Chest |
| <input type="checkbox"/> Carotid | <input type="checkbox"/> Abdomen |
| <input type="checkbox"/> Vertebrae | <input type="checkbox"/> Pelvis |
| <input type="checkbox"/> Aortic Arch | <input type="checkbox"/> Lower Extremities |
| <input type="checkbox"/> Renals | <input type="checkbox"/> Other: _____ |

Prior Studies Yes No
Where: _____

Follow-Up Appointment Yes No
When: _____

Allergies (iodine, x-ray dye/contrast) Yes No
Other: _____

| | | |
|-------------------------------------|------------------------------|-----------------------------|
| Pacemaker/Defibrillator | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Implanted Insulin/Pain or Tens Unit | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Surgery to Area | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Surgical/Aneurysm Clips | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Brain Surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stent | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Metal Fragments | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Metal in Eyes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ear Ossicle Prosthesis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Claustrophobic | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Renal (Kidney) Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Breastfeeding | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pregnant | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

REPORT INFORMATION

Films Deliver CD Report Only

Hand Carry Hand Carry Stat

CC: Patient Report to Dr.: _____

CC: Fax Number: _____

Patient Preparation for All Exams

- Please bring your health insurance information, forms and cards with you.
- Arrive 30 minutes prior to your exam to complete paperwork.
- If you need to reschedule your appointment, please call us at least 24 hours in advance.
- Patients who are improperly prepared for their exams may need to be rescheduled. Please check preparation instructions.
- Please leave valuables at home. UMI cannot be held responsible for lost belongings.
- Children 11 and under cannot be left unattended or go into the exam room with you.
- Patients should wear warm, comfortable, loose-fitting clothing without metal snaps, buttons or zippers. In some cases, patients may be asked to change into a gown or scrubs.
- Women may want to wear a sports bra without metal hooks or wires.
- If you are pregnant or breast feeding, or there's a possibility of pregnancy, please inform our staff prior to your appointment.
- If you have a history of allergic reactions to contrast dye, please inform our staff prior to your appointment.

Patient Preparation & Expectations

MRI

Time Varies

- Please inform staff if you have any implanted medical devices.
- Remove all metal objects including jewelry, hair pins, eyeglasses and credit cards.
- Our MRI scanner is a short bore with flared openings to better accommodate patients with space-related anxieties. However, if you are known to have space-related anxieties we encourage having a friend or family member in the room during your exam. If your physician has prescribed medication, be sure you have a designated driver.
- You will lie on a padded table as it is moved into the scanner. Multiple images are taken, during which time you will be asked to remain completely still and hold your breath for a few seconds at a time. You may feel air moved by its fan and hear the equipment make a series of knocking sounds, which are normal. At all times you will have two-way communication with the technologist.

X-RAY

Allow 30 minutes

- Most exams require no special preparation. You may eat, drink and take medications as you normally would.
- Depending on the exam, you will be asked to lie or stand still while the X-ray is performed.

AFTER YOUR EXAM

When your exam is complete, your images will be interpreted by a Board Certified Radiologist, who will provide a report to your physician within 24 hours of your exam. Your physician will review the exam results with you.

Driving Instructions

University Medical Imaging is behind Sacramento Heart

FROM RENO:

Travel SOUTH on HWY 80 (CAPITAL CITY FREEWAY)
EXIT Arden Way, travel EAST - RIGHT on Howe Avenue
RIGHT on University Ave. to 500 University Ave
Turn LEFT into parking lot

FROM HWY 50:

EXIT Howe Avenue, travel NORTH
LEFT on University Ave. to 500 University Avenue
Turn LEFT into parking lot

FROM STOCKTON:

Travel NORTH on HWY 99
EXIT to HWY 50 EAST - EXIT Howe Avenue, travel NORTH
LEFT on University Ave. to 500 University Ave
Turn LEFT into parking lot

