GO IMAGING

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Patient Information (required)

Patient Name:	DOB:
Cell Ph:	Home Ph:
Insurance:	Ins. Group #:
Ins. ID:	
ICD 10:	
Diagnosis:	

Physician Information (required)

Date:	
Physician Signature (required):	
Physician Name:	
Ph#:	Fax#:
Send CD w/ Patient: (Y / N)	
Special Instructions:	

Open Evenings and on Saturday by Appointment Only - Visit us Online at www.GO-Imaging.com

MRI

Specify w/o or w/wo contrast

	Exam		
	Brain	wo	w/wo
	Brain & IAC's	wo	w/wo
	Brain & Pituitary	wo	w/wo
	Brain & Post. Fossa	wo	w/wo
	Brain ATTN Sinuses	wo	w/wo
	Brain & Orbits	wo	w/wo
	Cervical	wo	w/wo
	Thoracic	wo	w/wo
	Lumbar	wo	w/wo
	Soft Tissue Neck	wo	w/wo
	Brach Plexus (Shoulder)	wo	w/wo
	Abdomen	wo	w/wo
	Pelvis	wo	w/wo
	MRCP (Abdomen w/o contrast		
	Other:		

Extremity ☐ R ☐ L

☐ Ankle	☐ Elbow	☐ Foot
☐ Forearm	☐ Hand	☐ Hip
☐ Humerus	☐ Knee	☐ Lower Leg
☐ Thigh	☐ Scapula	☐ Shoulder
☐ Wrist	☐ Arthrogram	
☐ w/wo contrast		

MRA

Specify w/o or w/wo contrast

	Exam		
	Head	w/o	
	MRV (Head)	w/o	
	Carotids	w/o	w/wo
	Aortic Arch (Chest)	w/ contrast	
	Abdomen	w/ contrast	
	Renals	w/ contrast	
	Other:	w/ contrast	

CT (*includes 3D rendering)

Specify w/o or w/wo contrast

	Exam			
	Brain	w	wo	w/wo
	IAC's	w	wo	w/wo
	Orbits*	w	wo	w/wo
	Facial Bones*	w	wo	w/wo
	Cervical*	w	wo	w/wo
	Thoracic*	w	wo	w/wo
	Lumbar*	w	wo	w/wo
	Soft Tissue Neck	w	wo	w/wo
	Chest	w	wo	w/wo
	Chest - Lung Screen	w	wo	w/wo
	Abdomen (Routine)	w	wo	w/wo
	Abdomen (Organ Specific Protocols)			w/wo
	☐ Pancreas ☐ Liver			
	☐ Renal ☐ Andrenal			
	Pelvis (Routine)	w	wo	w/wo
	Urogram Protocol			
	Kidney Stone Protocol			
	Sinuses ☐ Fusion			

Extremity ☐ R ☐ L

☐ Shoulder*	☐ Scapula*	☐ Humerus*
☐ Elbow*	☐ Forearm*	☐ Wrist*
☐ Hand*	☐ Hip*	☐ Femur*
☐ Knee*	☐ Lower Leg	☐ Ankle*
☐ Foot*	☐ Other: ____________	

CTA (All performed with IV contrast)

	Exam
	Brain
	Neck
	Chest – Aorta
	Chest – Pulmonary Embolism (PE)
	Upper Extremity
	Abdomen – Aorta
	Abdomen w/Runoffs – Aorta + Lower
	Pelvis – Aorta
	Lower Extremities
	Other:

SEDATION (MRI Only)

	Exam
	Oral Valium - Please administer one 5mgTablet. If needed, a second 5mg tablet would be administered.
	IV Valium

ULTRASOUND

	Exam
	Abdominal Aorta
	Abdominal Complete
	Abdominal Limitd (Gallbladder)
	Arterial Duplex
	☐ Upper Ext ☐ Lower Ext
	☐ Bilateral ☐ RT ☐ LT
	Breast
	Carotid Duplex
	Liver and Spleen
	Pelvic Complete Transabdominal
	Pelvic Complete Transvaginal
	Renal / Kidney
	Soft Tissue of Head and Neck
	Soft Tissue
	Testicular ☐ Unilateral ☐ Bilateral
	Thyroid (Vascular) ☐ Unilateral ☐ Bilateral
	Venous Duplex
	☐ Upper Ext ☐ Lower Ext
	☐ Bilateral ☐ RT ☐ LT

X-RAY

	Exam
	Orthopedic: ______________
	☐ RT ☐ LT ☐ Bilateral
	☐ Weight bearing
	Chest
	Abdomen
	Spine: ____________ ☐ Flex/Ext
	Other: