Affordable Imaging Services

Diagnostic Imaging Request

4424 Aicholtz Road, Suite D • Cincinnati, Ohio 45245 • Scheduling: (513) 753-8000 • Fax: (855) 595-1103

Patient Name_____ Phone Number_____

DOB_____ (Patients over 60 are required to have renal lab work within the last 30 days Prior to contrast administration.)

*PLEASE FAX DEMOGRAPHICS, LABS & INSURANCE CARD IF APPLICABLE.

Diagnosis (ICD-10 Required)_____ History_____

Routine ☐ (MRI within 24 hours. CT/US/ECHO 24-72) STAT Read ☐ Prior Imaging report for comparison ☐

MRI

*If patient has/had metal in their eyes, we require the patient to be cleared by their physician prior to their MRI scan.

W/Contrast ☐ W/O Contrast ☐

☐ Brain_____

☐ MRA_____

☐ Orbit, Face Neck_____

☐ Cervical ☐ Thoracic ☐ Lumbar

_____

☐ Abdomen_____

☐ Pelvis_____

☐ Upper Extremity Joint ☐ R ☐ L

☐ Lower Extremity Joint ☐ R ☐ L

☐ Other

CT

W/Contrast ☐ W/O contrast ☐

☐ Head_____

☐ CTA_____

☐ Facial Bones/Orbit_____

☐ Sinus_____

☐ Soft Tissue Neck_____

☐ Chest_____ ☐ Lung Screening

☐ Abdomen_____

☐ Abdomen & Pelvis_____

☐ Cervical ☐ Thoracic ☐ Lumbar

☐ Upper Extremity Joint ☐ R ☐ L

☐ Lower Extremity Joint ☐ R ☐ L

☐ Other_____

ULTRASOUND

☐ Aorta_____

☐ Carotid_____

☐ Thyroid/Soft Tissue Neck/Head_____

☐ Breast_____ ☐ R ☐ L

☐ Kidney/Bladder_____

☐ Renal Artery Duplex_____

☐ Abdomen_____

☐ Pelvic_____

☐ Transvaginal OB/GYN ☐ Non OB/GYN

☐ Extremity_____

☐ R ☐ L ☐ B ☐ Vascular ☐ Arterial

☐ Other_____

☐ Vascular Screening_____

ECHOCARDIOGRAM

☐ 2D Doppler w/Color flow

ORDERING PHYSICIAN_____ PHONE_____

SIGNATURE_____ FAX_____