



# Referral for Imaging Services

Phone: (407) 628-9100  
Fax: (407) 628-0748

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Home Phone \_\_\_\_\_ Daytime Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Appointment Date/Time \_\_\_\_\_ ICD-9 \_\_\_\_\_  
Diagnosis \_\_\_\_\_

Radiologist:  
Dr. Kenneth Hines, Jr.

Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Prior Studies  No  Yes, Exam location \_\_\_\_\_ Medical Records Release \_\_\_\_\_

I hereby authorize Emery Medical Solutions to act on my behalf to obtain any authorization for testing that I have ordered for the above patient. I hereby certify that the test(s) ordered are medically necessary for the diagnosis and treatment of the patient.

Physicians Signature \_\_\_\_\_ Date : \_\_\_\_\_

**MRI (Magnetic Resonance Imaging)**  With IV Contrast  Without IV Contrast  Contrast at Radiologist Discretion

<input type="checkbox"/> Brain	<input type="checkbox"/> Orbits	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Neck (soft tissue)	Shoulder	<input type="checkbox"/> Rt. <input type="checkbox"/> Lt.	Hand	<input type="checkbox"/> Rt. <input type="checkbox"/> Lt.
<input type="checkbox"/> Pituitary	<input type="checkbox"/> TMJ's	<input type="checkbox"/> C-Spine	<input type="checkbox"/> Abdomen attn: _____	Hip	<input type="checkbox"/> Rt. <input type="checkbox"/> Lt.	Ankle	<input type="checkbox"/> Rt. <input type="checkbox"/> Lt.
<input type="checkbox"/> IAC's	<input type="checkbox"/> Chest	<input type="checkbox"/> T-Spine	<input type="checkbox"/> MRA _____	Elbow	<input type="checkbox"/> Rt. <input type="checkbox"/> Lt.	Foot	<input type="checkbox"/> Rt. <input type="checkbox"/> Lt.
<input type="checkbox"/> Breast w/CAD	<input type="checkbox"/> L-Spine	<input type="checkbox"/> MRV _____	<input type="checkbox"/> Arthrogram _____	Wrist	<input type="checkbox"/> Rt. <input type="checkbox"/> Lt.	Knee	<input type="checkbox"/> Rt. <input type="checkbox"/> Lt.
		<input type="checkbox"/> Other: _____		Arm	<input type="checkbox"/> Rt. <input type="checkbox"/> Lt.	Leg	<input type="checkbox"/> Rt. <input type="checkbox"/> Lt.
						<input type="checkbox"/> Upper <input type="checkbox"/> Lower	<input type="checkbox"/> Upper <input type="checkbox"/> Lower

**CT (Computer Tomography)**  With IV Contrast  Without IV Contrast  Contrast at Radiologist Discretion

<p><b>For MRI &amp; CT contrast</b></p> <input type="checkbox"/> BUN/Creatinine	<input type="checkbox"/> Brain	<input type="checkbox"/> Orbits	<input type="checkbox"/> C-Spine	<input type="checkbox"/> CTA _____	<input type="checkbox"/> Chest (High Resolution)
	<input type="checkbox"/> Facial Bones	<input type="checkbox"/> TMJ's	<input type="checkbox"/> T-Spine	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Chest PE Protocol (STAT)
	<input type="checkbox"/> Temporal Bones	<input type="checkbox"/> Sinuses	<input type="checkbox"/> L-Spine	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Renal Protocol
	<input type="checkbox"/> Neck (soft tissue)			<input type="checkbox"/> Renal Stone Protocol	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> Upper Extremity (specify): _____			<input type="checkbox"/> Lower Extremity (specify): _____	

Results if tested within last 30 days

**Mammography / Bone Density (DEXA)**  Digital Screening Mammography w/CAD

Bone Densitometry  Digital Diagnostic Mammography w/CAD Additional Views , Breast US, MRI PRN

Bilateral  Unilateral

**Biopsy**  MRI Guided Breast Biopsy  US guided Breast Biopsy  US Guided Thyroid Biopsy

**X-Ray**

<input type="checkbox"/> Skull	<input type="checkbox"/> Neck (soft tissue)	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Ribs	<input type="checkbox"/> Rt. <input type="checkbox"/> Lt.	<input type="checkbox"/> Hip	<input type="checkbox"/> Rt. <input type="checkbox"/> Lt.
<input type="checkbox"/> Facial Bones	<input type="checkbox"/> Chest	<input type="checkbox"/> 1 view <input type="checkbox"/> 2 view	<input type="checkbox"/> Clavical	<input type="checkbox"/> Rt. <input type="checkbox"/> Lt.	<input type="checkbox"/> Femur	<input type="checkbox"/> Rt. <input type="checkbox"/> Lt.
<input type="checkbox"/> Paranasal Sinuses	<input type="checkbox"/> PA <input type="checkbox"/> Lat	<input type="checkbox"/> C-Spine	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Rt. <input type="checkbox"/> Lt.	<input type="checkbox"/> Knee	<input type="checkbox"/> Rt. <input type="checkbox"/> Lt.
<input type="checkbox"/> TMJ's	<input type="checkbox"/> Scoliosis Series	<input type="checkbox"/> AP/Lat <input type="checkbox"/> Complete <input type="checkbox"/> Flex/Ext	<input type="checkbox"/> Humerus	<input type="checkbox"/> Rt. <input type="checkbox"/> Lt.	<input type="checkbox"/> Tibia/Fibula	<input type="checkbox"/> Rt. <input type="checkbox"/> Lt.
<input type="checkbox"/> Nasal Bones	<input type="checkbox"/> SI Joints	<input type="checkbox"/> T-Spine	<input type="checkbox"/> Elbow	<input type="checkbox"/> Rt. <input type="checkbox"/> Lt.	<input type="checkbox"/> Ankle	<input type="checkbox"/> Rt. <input type="checkbox"/> Lt.
<input type="checkbox"/> Mandible	<input type="checkbox"/> Sacrum/Coccyx	<input type="checkbox"/> L-Spine <input type="checkbox"/> Flex/Ext	<input type="checkbox"/> Forearm	<input type="checkbox"/> Rt. <input type="checkbox"/> Lt.	<input type="checkbox"/> Foot	<input type="checkbox"/> Rt. <input type="checkbox"/> Lt.
	<input type="checkbox"/> Pelvis	<input type="checkbox"/> 3 view <input type="checkbox"/> Complete	<input type="checkbox"/> Wrist	<input type="checkbox"/> Rt. <input type="checkbox"/> Lt.	<input type="checkbox"/> Heel	<input type="checkbox"/> Rt. <input type="checkbox"/> Lt.
	<input type="checkbox"/> Other		<input type="checkbox"/> Hand	<input type="checkbox"/> Rt. <input type="checkbox"/> Lt.	<input type="checkbox"/> Toes	<input type="checkbox"/> Rt. <input type="checkbox"/> Lt.
			<input type="checkbox"/> Fingers	<input type="checkbox"/> Rt. <input type="checkbox"/> Lt.		

**Ultrasound**

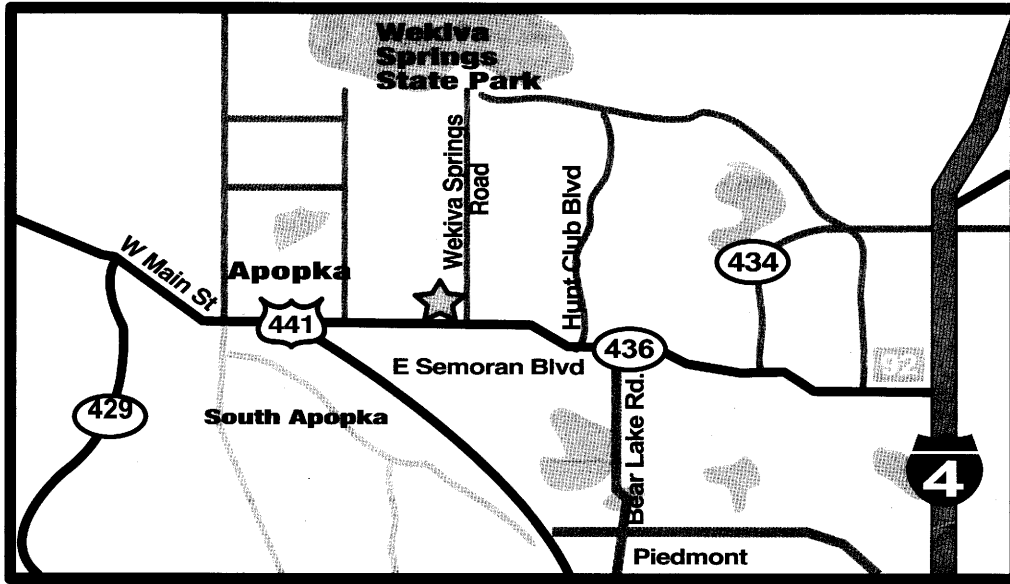
OB/GYN	Cardiac/Vascular	Abdominal	Superficial Structures
<input type="checkbox"/> Pelvic w / Transvaginal PRN	<input type="checkbox"/> Echocardiogram	<input type="checkbox"/> Abdominal Complete	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Fetal Limited < 12 wk gestation	<input type="checkbox"/> Carotid Doppler	<input type="checkbox"/> Abdominal Limited	<input type="checkbox"/> Scrotal
<input type="checkbox"/> Fetal Complete > 12 wks gestation	<input type="checkbox"/> Renal Doppler	(Liver, Gallbladder, Pancreas, Rt Kidney)	<input type="checkbox"/> Scrotal w/ doppler
<input type="checkbox"/> Single <input type="checkbox"/> Multiple	<input type="checkbox"/> Arterial Doppler - Limited (groin)	<input type="checkbox"/> Retroperitoneal Complete	<input type="checkbox"/> Extremity soft tissue
	<input type="checkbox"/> Venous <input type="checkbox"/> Arterial Doppler - Upper	(Kidneys, Bladder, Aorta)	<input type="checkbox"/> Other (specify): _____
	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Retroperitoneal Limited	
	<input type="checkbox"/> Venous <input type="checkbox"/> Arterial Doppler - Lower		
	<input type="checkbox"/> Left <input type="checkbox"/> Right		



\*\*\*See back for exam preparations\*\*\*

•2151 E. Semoran Blvd • Apopka, FL 32703 •





Emery Medical Solutions is located in the Wekiva Springs River Walk Plaza at the intersection of Wekiva Springs Road and State Route 436 (Semoran Blvd).

<p><b>Directions from Orlando:</b> I-4 East toward Daytona Beach. Take the SR-436 exit - Exit 92 - towards Altamonte Springs / Apopka Turn Left onto SR436, continue on 436 for 5.2 miles. Emery will be on the Right in Wekiva Springs River Walk Plaza.</p>	<p><b>Directions from Ocoee/Clermont:</b> SR 429 (toll road) to Apopka, Merge right onto US 441 toward Apopka. Merge left onto SR 436, continue east for 2 miles Emery will be on the Left in Wekiva Springs River Walk Plaza.</p>
<p><b>Directions from Sanford:</b> I-4 West toward Orlando. Take the SR-436 exit - Exit 92 - towards Altamonte Springs / Apopka Turn Right onto SR436, continue on 436 for 5.2 miles. Emery will be on the Right in Wekiva Springs River Walk Plaza.</p>	<p><b>Directions from Mt. Dora:</b> US 441 toward Apopka. Merge left onto SR 436, continue east for 2 miles Emery will be on the Left in Wekiva Springs River Walk Plaza.</p>

<b>CT SCAN</b>	<b>Exam Preps</b>	<b>ULTRASOUND</b>
<p><b>NPO after midnight or 4-6 hours before scheduled exam time.</b></p> <ul style="list-style-type: none"> <li>• CT Brain w/ &amp; w/o contrast</li> <li>• CT Orbits w/ contrast or CT Orbits w/ &amp; w/o contrast</li> <li>• CT Neck w contrast or CT Neck w/ &amp; w/o contrast</li> <li>• CT Chest w/ contrast or CT Chest w/ &amp; w/o contrast</li> </ul>	<p><b>Begin drinking 32oz of water 1 hour before the exam. Finish drinking ALL of the water before the appointment time. DO NOT VOID until after the exam.</b></p> <ul style="list-style-type: none"> <li>• Pelvic Ultrasound</li> <li>• Early Pregnancy Ultrasound (&lt; 12 weeks gestation)</li> </ul>	
<p><b>NPO after midnight or 4-6 hours before scheduled exam time</b> <b>*** Drink 1 bottle of contrast 1 hour prior to exam***</b></p> <ul style="list-style-type: none"> <li>• CT Abd w/o contrast or CT Abd w/ &amp; w/o contrast</li> </ul> <p><b>*** Drink 1 bottle of contrast 2 hours prior and 1 bottle of contrast 1 hour prior to exam***</b></p> <ul style="list-style-type: none"> <li>• CT Abd/Pelvis w/o contrast (Note: Patient will be instructed to drink more barium when he or she arrives for the exam)</li> <li>• CT Abd/Pelvis w/ &amp; w/o contrast (Note: Patient will be instructed to drink more barium when he or she arrives for the exam)</li> <li>• CT Pelvis w/o contrast</li> <li>• CT Pelvis w/ &amp; w/o contrast</li> </ul>	<p><b>Begin drinking 24oz of water 1 hour before the exam. Finish drinking ALL of the water before the appointment time. DO NOT VOID until after the exam.</b></p> <ul style="list-style-type: none"> <li>• Renal Ultrasound - NPO 6-8 hours before scheduled exam time.</li> <li>• Bladder Ultrasound</li> <li>• Late Pregnancy (&gt;12 weeks gestation)</li> </ul>	
<p><b>ALL CT EXAMS USING IV CONTRAST</b></p> <p><b>A preliminary BUN and Creatinine level must be obtained within 30 days of the exam for all patients who are diabetic, over the age of 45 and/or have a history of kidney failure.</b></p>	<p><b>NPO after midnight or 6-8 hours before scheduled exam time</b></p> <ul style="list-style-type: none"> <li>• Abdominal Ultrasound</li> <li>• Gallbladder/Liver Ultrasound</li> <li>• Aorta Ultrasound</li> </ul>	
<p><b>MRI</b></p> <p><b>NPO after midnight or 4-6 hours before scheduled exam time.</b></p> <ul style="list-style-type: none"> <li>• MR Abd w/o contrast</li> <li>• MR Abd w/ &amp; w/o contrast</li> <li>• MR Abd/Pelvis w/o contrast</li> <li>• MR Abd/Pelvis w/ &amp; w/o contrast</li> </ul>	<p><b>MAMMOGRAPHY</b></p> <p><b>No DEODORANT, lotions or powders used on the chest and underarm areas on the day of the exam.</b></p>	