



**FOR BOTH LOCATIONS:**

General Scheduling: (907) 212-3151 ▪ Toll-free: (888) 458-3151

MRI, CT, PET-CT Scheduling: (907) 212-3146 ▪ Fax For All Orders: (907) 212-5828

**REPORTING INSTRUCTIONS**

- STAT Call Report – ph# \_\_\_\_\_
- STAT Fax Report – fx# \_\_\_\_\_
- Pt. to return with CD

<b>PATIENT LAST NAME (REQUIRED)</b>	<b>FIRST</b>	<b>M</b>	<b>DATE OF BIRTH (REQUIRED)</b>	<b>PT. HM. PHONE</b>	<b>CELL PHONE</b>
<b>ORDERING CLINICIAN (REQUIRED)</b>			<b>CLINICIAN SIGNATURE (REQUIRED – NO STAMPS)</b>		<b>CLINICIAN PHONE</b>
SEND ADDITIONAL COPIES OF REPORT TO _____				<b>PREGNANT?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>HISTORY/SYMPTOMS/DIAGNOSIS (REQUIRED) – PLEASE INCLUDE ICD-9 CODE(S)</b>					

**CT** ANCH & EAGLE RIVER

**BUN/Creat.** \_\_\_\_\_

With IV Contrast  Without IV Contrast

With & Without IV Contrast

Head  Abdomen

Neck  Renal Stone Study

Chest  Pelvis

PE Study  Abdomen and Pelvis

Chest Hi-Res  CT IVP (urogram)

(interstitial lung disease)  CT Enterography

Maxillo Facial (small bowel)

Sinus Complete  Sinus Limited

IACs/Temporal Bone/Pituitary

Orbits

C-Spine  T-Spine  L-Spine

Extremity \_\_\_\_\_

**CT Angiogram**

Carotids (aortic arch to Circle of Willis)

Intracranial/Circle of Willis

Thoracic Angiogram

Renal Angio

ABD/Pelvic Angio (for AAA)

ABD Aortogram & Lower Extremity Runoff

Other \_\_\_\_\_

**ULTRASOUND** ANCH & EAGLE RIVER

Abdominal (GB, Liver, Pancreas, Spleen, Kidneys, Aorta)

Aorta  Biophysical Profile

Cranial

Hysterosonogram

Obstetric EDC \_\_\_\_\_ LMP \_\_\_\_\_

Pelvic w/Transvaginal

Renal/Bladder  Testicular

Thyroid  Thyroid Biopsy/FNA

Vascular Screening (self pay)

**Doppler Studies**

Mesenteric  Porto-hepatic  Renal Arterial

Venous Doppler

Arms  R  L Legs  R  L

Carotid Doppler  Liver Transplant

Renal Transplant

Ankle Brachial Index (ABIs)

(Segmental, Resting & Exercise prn)

Groin Doppler (Post Heart Cath)

Vein Mapping

Arms  R  L Legs  R  L

Other \_\_\_\_\_

**PET – CT** ANCH

Special order form required, call 212-2879.

**BONE DENSITOMETRY** ANCH

DXA L-Spine & Hip  DXA with IVA

Body Fat Analysis

**MRI** ANCH

With & Without Contrast

With Contrast as Necessary

**Neurologic/Spine**

Brain  Brain Without Contrast

Orbits  Brain Spectroscopy

Pituitary

Internal Auditory Canal

Fifth Cranial Nerve

Pre-op Stealth Brain  STRS Brain

Metastatic Spine Survey

Soft Tissue Neck

Brachial Plexus

C-Spine  T-Spine  L-Spine\*

Reason (check one):  Disc  Infection

MS  Mets

\*History of prior lumbar surgery?  Yes  No

**Musculoskeletal**

	Right	Left
<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Shoulder with Arthrogram	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Wrist	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hip with Arthrogram	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Knee	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ankle	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>

**Body**

Breast – special order form required, call 212-3146.

Pelvis

Pre-embolization Uterus

Liver with Eovist

MRCP

Renal  Adrenal  Pancreas

**MR Angiogram**

Carotids (from aortic arch to Circle of Willis)

Intracranial/Circle of Willis

Thoracic Aortogram

Renal MRA

Abdominal Aortogram & Lower Extremity Runoff

Other \_\_\_\_\_

**BREAST** ANCH

\*Indicate location of abnormality

**Digital Mammography** Right Left

Screening

Diagnostic Bilateral Mammogram\*

Diagnostic Unilateral Mammogram\*

Cone/Magnification Views, if needed

Mammogram/Augmentation

Ductogram

Stereotactic Biopsy

Other \_\_\_\_\_

**Ultrasound**

Breast Ultrasound\*

if needed

**Patients 34 or Younger**

Diagnostic Mamm. (if needed)

Breast Ultrasound Aspiration

Breast Ultrasound Biopsy

**DIAGNOSTIC RADIOLOGY** ANCH & EAGLE RIVER

**Gastrointestinal**

Barium Swallow (Esophagram)  Upper GI

Small Bowel Series  Barium Enema

Barium Enema Air Contrast

**Hysterosalpingogram**

Sinus Series  Skull

Sinus/Waters only  Facial Bones

Chest

Abdomen (KUB)  Ribs \_\_\_\_\_

**Spine**  **Scoliosis Series**

Cervical  Thoracic  Lumbar

Complete  Limited \_\_\_\_\_

**Extremity** #Views Right Left

<input type="checkbox"/> Hand	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Finger	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Wrist	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Forearm	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Elbow	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Humerus	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Shoulder	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Foot	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Toes	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ankle	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Knee	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Tib-Fib	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Femur	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hip	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Standing Knees AP	_____	<input type="checkbox"/>	<input type="checkbox"/>

Other \_\_\_\_\_

**OFFICE COPY (WHITE) – KEEP FOR YOUR RECORDS • PATIENT COPY (YELLOW) – PREP INSTRUCTIONS ON BACK OF YELLOW COPY ONLY**



# Patient Instructions

**Call us at (907) 212-3151 to schedule and pre-register for your appointment at either location, or accomplish this online at [www.provimaging.com](http://www.provimaging.com) • For additional prep information, go to [www.provimaging.com/prep](http://www.provimaging.com/prep)  
Medications should be taken and where fasting is required, a small amount of water may be taken to swallow pills.**

## Diagnostic Radiology

Procedure	Patient Instructions
<input type="checkbox"/> Barium Swallow	Nothing to eat or drink (including water) after midnight the evening before.
<input type="checkbox"/> Upper GI	
<input type="checkbox"/> Small Bowel Series*	
<input type="checkbox"/> Barium Enema	You will need to pick up a BE prep kit.
<input type="checkbox"/> Barium Enema with Air Contrast	Follow the instructions included inside the front cover.

All other general radiology exams require no prep.

## PET-CT

Special diet needed for oncology patients, please call (907) 212-2879 for instructions.

## CT Scan

<input type="checkbox"/> CT Abdomen	Do not eat or drink anything four (4) hours prior to exam. Thirty (30) minutes before exam, drink <b>one (1) bottle</b> of oral CT contrast.
<input type="checkbox"/> CT Abdomen/Pelvis prior to 9 a.m.	At 9 p.m. the evening before exam, drink <b>one (1) bottle</b> of oral CT contrast. You may eat and drink as desired after taking the oral contrast until midnight. On the morning of exam, do not eat or drink anything other than the oral CT contrast. Thirty (30) minutes before exam, drink the <b>second bottle</b> of oral CT contrast.
<input type="checkbox"/> CT Abdomen/Pelvis after 9 a.m.	Drink <b>one (1) bottle</b> of oral CT contrast three (3) hours prior to exam. Nothing to eat after the <b>first bottle</b> of oral CT contrast. Thirty (30) minutes before exam, drink the <b>second bottle</b> of oral CT contrast.
<input type="checkbox"/> CT Enterography	Do not eat or drink four (4) hours prior to exam.

## Ultrasound

For abdomen, aorta, liver transplant, mesenteric doppler, port-hepatic doppler, or renal arterial doppler: do not eat or drink (including water) after midnight the evening before the exam.

For breast, carotid doppler, cranial, testicular, renal transplant venous doppler, ABIs, groin doppler, and vein mapping: **no patient prep is necessary.**

<input type="checkbox"/> Pelvis/OB	One and one-half hours before the exam, start drinking 32 oz. of water. Complete drinking water one hour prior to exam. Do not urinate until after test.
<input type="checkbox"/> Renal	Drink plenty of clear liquids day prior to exam. Day of exam, drink 24 oz. of water. Complete drinking 30 minutes prior to exam. Do not urinate until after test.

## Bone Densitometry

No calcium supplements the day of your exam. Wear comfortable clothing without zippers or metal. Do not schedule Nuclear Medicine or studies with Barium prep within two days prior to exam.

## Digital Mammography

No deodorant, powder or lotion. Mobile screening mammography is also available.

## MRI

Patients will be asked to remove all metal from their person (i.e., earrings, watches, bobby pins, barrettes, etc.) and credit cards. Lockers are provided. It's helpful if patient's clothing is comfortable (i.e., sweats) and doesn't include metal buttons, snaps or zippers.

For MRCP, MRAs of abdomen or renals, MRIs of the liver, pelvis and abdomen, the patient should not have anything to drink (including water) or eat 4 hours prior to exam.

**Renal patients:** If you have a history of kidney failure and are scheduled for an MRI with IV contrast, please give us a call as soon as possible before your scheduled appointment. Our technologist will be checking your laboratory results and consulting a radiologist to determine the safest way to proceed with your examination.

