IMAGING ASSOCIATES OF PROVIDENCE
A Providence Partner

TODAY'S DATE:_____ EXAM DATE:_____

REPORTING INSTRUCTIONS
☐ Routine Report ☐ Call Report
☐ Call report, patient wait
☐ Phone #_____
☐ Fax #_____
☐ Patient to return with films
☐ Patient to return with CD

South Anchorage
2000 Abbott Rd.
Anchorage, AK 99507
Phone (907) 222-0200
Fax (907) 222-0201
Toll Free 1-800-818-9392

Patients: In order to expedite your appointment, please pre-register by calling the number provided on this form.

PATIENT'S LAST NAME FIRST M	PT. PHONE NUMBER	DATE OF BIRTH
ORDERING CLINICIAN	CLINICIAN SIGNATURE	
SEND ADDITIONAL COPIES OF REPORT TO	PREGNANT? ☐ YES ☐ NO	
CLINICAL DATA INDICATING MEDICAL NECESSITY		

3 Tesla MRI

☐ **With IV Contrast** ☐ **Without IV Contrast**
☐ **With and Without IV**

Neurologic/Spine
☐ Brain
☐ Orbits
☐ Pituitary
☐ Internal Auditory Canal
☐ Treatment Planning Stealth Brain
☐ Metastatic Spine Survey
☐ Soft Tissue Neck
☐ Brachial Plexus
☐ C-Spine ☐ T-Spine ☐ L-Spine
* History of lumbar spine surgery? Yes No

Musculoskeletal	Right	Left
☐ Shoulder	☐	☐
☐ Wrist	☐	☐
☐ Hip	☐	☐
☐ Knee	☐	☐
☐ Ankle	☐	☐

Body
☐ Abdominal/Pelvic Survey
☐ Routine Liver with Gadolinium
☐ Liver with Feridex
☐ MRCP
☐ Renal ☐Adrenal ☐ Pancreas
☐ Pelvis

MR Angiogram
☐ Carotids (from aortic arch to Circle of Willis)
☐ Intracranial/Circle of Willis
☐ Thoracic Aortogram
☐ Renal MRA
☐ Abdominal Aortogram & Lower Extremity Runoff

Other MRI (not specified above)
☐ _____

MULTI-SLICE CT

BUN/Creatinine _____
☐ **With IV Contrast** ☐ **Without IV Contrast**
☐ **With and Without IV**
☐ Head ☐ Abdomen
☐ Neck ☐ CT Renal Stone Study
☐ Chest ☐ Pelvis
☐ Chest High Resolution (interstitial lung disease)
☐ PE Study ☐ Abdomen and Pelvis
☐ Extremity _____
☐ CT IVP (CT Urogram)
☐ Maxillo-Facial
☐ Sinus Complete ☐ Sinus Limited (with high resolution coronal reformats)
☐ IACs/Temporal Bone/Pituitary
☐ Orbits
☐ C-Spine ☐ T-Spine ☐ L-Spine

CT Angiogram
☐ Carotids (aortic arch to Circle of Willis)
☐ Intracranial/Circle of Willis
☐ Thoracic Angiogram
☐ Renal Angio
☐ ABD Aortogram & Low Extremity Runoff
☐ ABD Angio (for aortic aneurysm)

Other CT (not specified above)
☐ _____

ULTRASOUND

☐ Abdominal (GB, Liver, Pancreas, Spleen, Kidneys, Aorta)
☐ Abdominal Limited _____
☐ Renal/Bladder
☐ Renal Transplant
☐ Renal Artery Duplex
☐ Pelvic w/ Transvag
☐ Obstetric EDC _____ LMP_____
☐ Biophysical Profile
☐ Testicular
☐ Thyroid ☐ Thyroid biopsy
☐ Aorta
☐ Carotid Duplex
☐ Mesenteric ☐ Porta-hepatic
☐ Groin Duplex (Post Heart Cath)
☐ Vein Mapping UE ☐ R ☐ L
☐ Venous Doppler
UE ☐ R ☐ L LE ☐ R ☐ L
☐ Venous Reflux
☐ Other U/S _____

DIAGNOSTIC RADIOLOGY

☐ Sinus/Waters' Only ☐ Facial Bones
☐ Chest
☐ Abdomen (KUB)
☐ Abdomen – 2view

Spine	# Views
☐ Cervical	_____
☐ Thoracic	_____
☐ Lumbar	_____
☐ With Flexion/Extension	

Extremity	# Views	Right	Left
☐ Hand	_____	☐	☐
☐ Finger	_____	☐	☐
☐ Wrist	_____	☐	☐
☐ Forearm	_____	☐	☐
☐ Hip	_____	☐	☐
☐ Humerus	_____	☐	☐
☐ Shoulder	_____	☐	☐
☐ Foot	_____	☐	☐
☐ Ankle	_____	☐	☐
☐ Knee	_____	☐	☐
☐ Tib-Fib	_____	☐	☐
☐ Femur	_____	☐	☐
☐ Standing AP Knees	_____	☐	☐

Other (not specified above)
☐ _____

Digital Mammography/Breast Imaging

Please indicate location of abnormality

Digital Mammography
☐ Screening

Ultrasound
☐ Breast Ultrasound R L
☐ *if needed*