

OVAL MRI

"One size fits all"



LABS

BUN Creatinine

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Bradenton, FL 34210

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www.bowesimagingcenter.com

Patient's Name: _____ Physician's Name: _____

D.O.B.: _____ Physician's Signature: _____

Indication: _____ CC: _____

Diagnosis: _____ **Appointment On:** _____

SAME DAY APPOINTMENTS

AVAILABLE EVENINGS & WEEKENDS

MRI - NEURO/BODY		Without	With/Without	Contrast at RAD Discretion
VEN BOLD		<input type="checkbox"/>		
DTI (Diffusion Tensor Imaging)		<input type="checkbox"/>		
BRAIN		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IAC'S		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PITUITARY		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ORBITS		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CERVICAL SPINE		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
THORACIC SPINE		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LUMBAR SPINE		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NECK (SOFT TISSUE)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BREAST MRI	R L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CHEST		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ABDOMEN		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PELVIS		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TMJ		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MRI - MUSCULOSKELETAL		Without	With/Without	Contrast at RAD Discretion
SHOULDER	R L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ELBOW	R L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WRIST	R L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HAND	R L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIP	R L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
KNEE	R L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ANKLE	R L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FOOT	R L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MRA - ANGIOGRAPHY		Without	With/Without
CIRCLE OF WILLIS		<input type="checkbox"/>	
CAROTID ARTERIES		<input type="checkbox"/>	<input type="checkbox"/>
AORTA			
THORACIC			<input type="checkbox"/>
ABDOMINAL			<input type="checkbox"/>
RENAL ARTERIES			<input type="checkbox"/>
LOWER EXTREMITY-RUNOFF	R L		<input type="checkbox"/>
UPPER EXTREMITIES	R L		<input type="checkbox"/>

DEXA	
<input type="checkbox"/> BONE DENSITY	<input type="checkbox"/> OTHER: _____

X-RAY	
CHEST PA & LAT	<input type="checkbox"/>
ABDOMEN, KUB	<input type="checkbox"/>
ABDOMINAL SERIES	<input type="checkbox"/>
PELVIS	<input type="checkbox"/>
C-SPINE	<input type="checkbox"/>
T-SPINE	<input type="checkbox"/>
L-SPINE	<input type="checkbox"/>
SHOULDER	<input type="checkbox"/> R L
ELBOW	<input type="checkbox"/> R L
WRIST	<input type="checkbox"/> R L
HAND	<input type="checkbox"/> R L
HIP	<input type="checkbox"/> R L
KNEE	<input type="checkbox"/> R L
ANKLE	<input type="checkbox"/> R L
FOOT	<input type="checkbox"/> R L
OTHER:	_____

CT		
<input type="checkbox"/> Without	<input type="checkbox"/> With/Without	<input type="checkbox"/> Contrast at Radiologist Discretion
HEAD <input type="checkbox"/> Oral Contrast		
<input type="checkbox"/> HEAD	<input type="checkbox"/> SINUS	<input type="checkbox"/> TMJ
<input type="checkbox"/> MANDIBLE	<input type="checkbox"/> ORBITS	<input type="checkbox"/> NECK (SOFT TISSUE)
<input type="checkbox"/> TEMPORAL BONE	<input type="checkbox"/> OTHER _____	
SPINE		
<input type="checkbox"/> CERVICAL	<input type="checkbox"/> THORACIC	<input type="checkbox"/> SACRUM/COCCYX
<input type="checkbox"/> LUMBAR	<input type="checkbox"/> OTHER _____	
MUSCULOSKELETAL		
<input type="checkbox"/> ANKLE: R L	<input type="checkbox"/> KNEE: R L	<input type="checkbox"/> HIP: R L
<input type="checkbox"/> ELBOW: R L	<input type="checkbox"/> SHOULDER: R L	<input type="checkbox"/> OTHER _____
BODY		
<input type="checkbox"/> CHEST	<input type="checkbox"/> RENAL COLIC	<input type="checkbox"/> UROGRAM
<input type="checkbox"/> ABDOMEN	<input type="checkbox"/> PELVIS	<input type="checkbox"/> OTHER _____
CTA		
<input type="checkbox"/> ABDOMEN	<input type="checkbox"/> PULMONARY ARTERIES	<input type="checkbox"/> THORAX
<input type="checkbox"/> CAROTID	<input type="checkbox"/> OTHER _____	

ULTRASOUND		
<input type="checkbox"/> CAROTIDS	<input type="checkbox"/> EXTREMITY	<input type="checkbox"/> PELVIC
<input type="checkbox"/> RENAL DOPPLER	<input type="checkbox"/> ABDOMINAL	<input type="checkbox"/> BREAST
<input type="checkbox"/> RENAL ULTRASOUND	<input type="checkbox"/> AAA	
<input type="checkbox"/> VENOUS: LEG: R L BILAT	ARM: R L BILAT	
<input type="checkbox"/> ARTERIAL: LEG: R L BILAT	ARM: R L BILAT	
<input type="checkbox"/> OTHER: _____		

DIGITAL MAMMOGRAM	
<input type="checkbox"/> DIAG - UNILATERAL R L	<input type="checkbox"/> DIAG - BILATERAL
<input type="checkbox"/> SCREENING	
<input type="checkbox"/> ADDITIONAL VIEW _____	
<input type="checkbox"/> OTHER: _____	

STAT FAX to: _____

Report Only Films with Patient CD with Patient

STAT CALL to: _____

Films & Report to Office by: _____