OVAL MRI
❑ "One size fits all"

6207 Cortez Road W.
Bradenton, FL 34210

HIGH-V
❑ 80 CM

Phone (941) 782-0490
Fax (941) 782-0496
www.bowesimagingcenter.com

Patient's Name: ______________________ Physician's Name: ______________________

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

Indication: ______________________ CC: ______________________

Diagnosis: ______________________ **Appointment On:** ______________________

SAME DAY APPOINTMENTS

MRI - NEURO/BODY

	Without	With/Without	Contrast at RAD	Advanced MARS
VEN BOLD	❑			
DTI (Diffusion Tensor Imaging)	❑			
BRAIN	❑	❑	❑	❑
IAC'S	❑	❑	❑	❑
PITUITARY	❑	❑	❑	❑
ORBITS	❑	❑	❑	❑
CERVICAL SPINE	❑	❑	❑	❑
THORACIC SPINE	❑	❑	❑	❑
LUMBAR SPINE	❑	❑	❑	❑
NECK (SOFT TISSUE)	❑	❑	❑	❑
BREAST MRI R L	❑	❑	❑	❑
CHEST	❑	❑	❑	❑
ABDOMEN	❑	❑	❑	❑
PELVIS	❑	❑	❑	❑
TMJ	❑	❑	❑	❑

MRI - MUSCULOSKELETAL

			Without	With/Without	Contrast at RAD	Advanced MARS
SHOULDER	R	L	❑	❑	❑	❑
ELBOW	R	L	❑	❑	❑	❑
WRIST	R	L	❑	❑	❑	❑
HAND	R	L	❑	❑	❑	❑
HIP	R	L	❑	❑	❑	❑
KNEE	R	L	❑	❑	❑	❑
ANKLE	R	L	❑	❑	❑	❑
FOOT	R	L	❑	❑	❑	❑

MRA - ANGIOGRAPHY

	Without	With/Without
CIRCLE OF WILLIS	❑	
CAROTID ARTERIES	❑	❑
AORTA		
THORACIC		❑
ABDOMINAL		❑
RENAL ARTERIES		❑
LOWER EXTREMITY-RUNOFF R L		❑
UPPER EXTREMITIES R L		❑

❑ STAT FAX to: ______________________

❑ STAT CALL to: ______________________

X-RAY

CHEST PA & LAT	❑	SHOULDER	❑	R	L
ABDOMEN, KUB	❑	ELBOW	❑	R	L
ABDOMINAL SERIES	❑	WRIST	❑	R	L
PELVIS	❑	HAND	❑	R	L
C-SPINE	❑	HIP	❑	R	L
T-SPINE	❑	KNEE	❑	R	L
L-SPINE	❑	ANKLE	❑	R	L
		FOOT	❑	R	L

OTHER: ______________________

CT

❑ Without ❑ With/Without ❑ Contrast at Radiologist Discretion

HEAD ❑ Oral Contrast ❑ LABS

- ❑ HEAD ❑ SINUS ❑ TMJ
- ❑ MANDIBLE ❑ ORBITS ❑ NECK (SOFT TISSUE)
- ❑ TEMPORAL BONE ❑ OTHER __________

SPINE

- ❑ CERVICAL ❑ THORACIC ❑ SACRUM/COCCYX
- ❑ LUMBAR ❑ OTHER __________

MUSCULOSKELETAL

- ❑ ANKLE: R L ❑ KNEE: R L ❑ HIP: R L
- ❑ ELBOW: R L ❑ SHOULDER: R L ❑ OTHER __________

BODY

- ❑ CHEST ❑ RENAL COLIC ❑ UROGRAM
- ❑ LOW DOSE CT CHEST ❑ ABDOMEN ❑ PELVIS

CTA

- ❑ ABDOMEN ❑ PULMONARY ARTERIES ❑ THORAX
- ❑ CAROTID ❑ OTHER __________

ULTRASOUND

❑ CAROTIDS ❑ EXTREMITY ❑ PELVIC

❑ RENAL DOPPLER ❑ ABDOMINAL ❑ BREAST

❑ RENAL ULTRASOUND ❑ AAA

❑ VENOUS: LEG: R L BILAT ARM: R L BILAT

❑ ARTERIAL: LEG: R L BILAT ARM: R L BILAT

❑ OTHER: ______________________

DIGITAL MAMMOGRAM

❑ DIAG - UNILATERAL R L ❑ DIAG - BILATERAL

❑ SCREENING

❑ ADDITIONAL VIEW ______________________

❑ US IF NECESSCARY ______________________

DEXA

❑ BONE DENSITY ❑ OTHER: __________

AVAILABLE EVENINGS & WEEKENDS