SHICARE RADIOLOGY NETWORK

Appointment
Date:
Time:

TEL: 877-922-5111 • FAX: 310-715-8245 • www.SHICARE.com

PLEASE CALL OR VISIT US ONLINE TO SCHEDULE AN APPOINTMENT AND FOR DIRECTIONS TO OUR CENTER LOCATIONS OR **SIMPLY FAX US YOUR ORDER**

BOARD CERTIFIED RADIOLOGISTS • QUALITY SERVICE & TIMELY REPORTS

Patient

Name: _____ Male: ____ Female: ____ D.O.B: _____

Home Phone: (____)_____ Cell/Work Phone: (____)_____

❑ Private Insurance ❑ Personal Injury ❑ Worker's Compensation ❑ Bill Doctor ❑ Bill Patient ❑ Other

Examination Info

Examination to Perform: **Diagnosis:**

MRI

❑ **CLOSED** ❑ **OPEN**
❑ **Contrast** ❑ **No Contrast**
❑ Arthrogram ❑ MRA
❑ Head/Brain
❑ Sinuses ❑ Breast (L, R, Both)
❑ Neck-Soft Tissue
❑ Cervical Spine ❑ Carotid
❑ Thoracic Spine ❑ IAC
❑ Lumbar Spine ❑ Chest
❑ Abdomen
❑ Pelvic
❑ Hip (L, R, Both)
❑ Knee (L, R, Both)
❑ Foot (L, R, Both)
❑ Ankle (L, R, Both)
❑ Shoulder (L, R, Both)
❑ Elbow (L, R, Both)
❑ Wrist (L, R, Both)
❑ Hand (L, R, Both)
❑ TMJ (L, R, Both)
❑ Fingers (L, R, Both)
❑ Thumb (L, R, Both)
❑ Brachialplexus
❑ Other _____

CT SCAN

❑ **Contrast**
❑ **No Contrast**
❑ Head/Brain
❑ Sinuses
❑ Neck-Soft Tissue
❑ Cervical Spine
❑ Lumbar Spine
❑ Chest
❑ Abdomen
❑ Pelvic
❑ Hip (L, R, Both)
❑ Knee (L, R, Both)
❑ Foot (L, R, Both)
❑ Ankle (L, R, Both)
❑ Shoulder (L, R, Both)
❑ Elbow (L, R, Both)
❑ Wrist (L, R, Both)
❑ Hand (L, R, Both)
❑ TMJ (L, R, Both)
❑ Dental CT
❑ Mandible ❑ Maxilla
❑ Bone Density/Dexa
❑ Other _____

X-RAY

HEAD
❑ Skull
❑ Mandible
❑ Mastoid
❑ Facial Bones
❑ Sinuses
❑ Neck-Soft Tissue

SPINE
❑ Cervical Spine
❑ Thoracic Spine
❑ Lumbar Spine
❑ Sacrum
❑ Coccyx

EXTREMITIES
❑ Clavicle (L, R, Both)
❑ Scapula (L, R, Both)
❑ Shoulder (L, R, Both)
❑ Humerus (L, R, Both)
❑ Elbow (L, R, Both)
❑ Forearm (L, R, Both)
❑ Wrist (L, R, Both)
❑ Hand (L, R, Both)
❑ Pelvis ❑ Hip (L, R, Both)
❑ Femur (L, R, Both) ❑ Ankle (L, R, Both)
❑ Knee (L, R, Both) ❑ Foot (L, R, Both)
❑ Tibia-Fibula (L, R, Both)
❑ Other _____

CHEST
❑ Chest (1-view)
❑ Chest (2-view)
❑ Ribs (L, R, Both)
❑ Sternum
❑ Upper G.I.

MAMMOGRAPHY

❑ Left ❑ Right ❑ Bilateral ❑ **Routine** ❑ **Diagnostic**

Ultrasound

❑ Thyroid
❑ Abdomen - General
❑ Gallbladder
❑ Kidney
❑ Pelvic
❑ OB
❑ Aorta
❑ Breast (L, R, Both)
❑ Prostate
❑ Other _____

NUCLEAR MEDICINE:

❑ Bone Scan (Limited, Multiple)
❑ Pet Scan
❑ Hida Scan

OTHER :

Please Specify:

_____
_____
_____
_____

Referring Physician

Doctor: _____

Phone: (_____) _____

Fax: (_____) _____

Physician's Signature: _____

Attorney Name _____

Attorney Phone # _____

Attorney Fax # _____

Date of Injury _____

❑ **STAT**
❑ PT is Claustrophobic
❑ Give CD/Films to the Patient
❑ Send CD of Images or Films to Doctor's office