9000 Waukegan Road Suite # 110
Morton Grove, IL 60053
P: 847-213-2700 F: 847-213-2709
www.3Timaging.com

PATIENT'S NAME: ______________________ AGE:_____

PATIENT'S PHONE#: ______________________

PHYSICIAN: ______________________

CLINICAL HISTORY/INDICATION: ______________________

RQI # / Pre-Certification #: ______________________

Date: ______________________

ICD-10: ______________________

cc/NAME: ______________________ FAX NUMBER: ______________________

PHYSICIAN'S SIGNATURE: ______________________

PERTINENT CLINICAL DIAGNOSIS REQUIRED. (DO NOT USE "RULE OUT", "POSSIBLE", "SUSPECTED" OR "FOLLOW-UP" DIAGNOSIS. USE SPECIFIED CODE #'S, SIGNS, SYMPTOMS, PATIENT COMPLAINTS, KNOWN DIAGNOSIS.)

MRI SCREENING

- ☐ PACEMAKER
- ☐ PREGNANT
- ☐ CEREBRAL ANEURYSM CLIPS
- ☐ METALLIC FOREIGN BODY IN EYE
- ☐ HISTORY OF WORKING WITH METAL
- ☐ OCULAR TRAUMA
- ☐ OTHER NON-ORTHOPEDIC METAL IMPLANTS

CT CONTRAST SCREENING

- ☐ DIABETES
- ☐ RENAL DISEASE
- ☐ AGE OVER 60
- ☐ IODINE / CT CONTRAST ALLERGY (Please call our office)
- ☐ PREGNANT
- ☐ GLUCOPHAGE/GLUCOVANCE
- ☐ BUN/CRE Testing @ 3T

IF ANY OF THE ABOVE ARE CHECKED, BUN/CREATININE WITHIN 30 DAYS IS REQUIRED.

BUN______ Cr______ DATE___/___/_____

☐ INTRAVENOUS CONTRAST PER RADIOLOGIST DISCRETION (If you do not select this option, please select a contrast option where applicable.)

3T MRI

	Options	Exam
	wo w/wo	BRAIN
	w/wo	IAC'S
	w/wo	BRAIN & IAC'S
	w/wo	PITUITARY
	w/wo	ORBITS
	B	BREAST
	wo w/wo	CERVICAL SPINE
	wo w/wo	THORACIC SPINE
	wo w/wo	LUMBAR SPINE
	R L w/wo	BRACHIAL PLEXUS
	wo	Intracranial MRA
	wo w/wo	Carotid / Neck MRA
	w/wo	Thoracic Aorta MRA
	w/wo	Abdominal Aorta / Renal MRA
	w/wo	UE/LE PERIPHERAL MRA
	wo w/wo	NECK SOFT TISSUE
	wo w/wo	CHEST
	wo w/wo	ABDOMEN
	wo w/wo	MRCP
	wo w/wo	PELVIS
	R L B	SHOULDER
	R L B	ELBOW
	R L B	WRIST
	R L B	HIP OSSEOUS & PELVIS
	R L B	KNEE
	R L B	ANKLE
	R L B	FOOT

ARTHROGRAM

WOMEN'S IMAGING

	Exam
	DIGITAL MAMMOGRAPHY
	Screening
	Diagnostic
	BREAST ULTRASOUND
	3T BREAST MRI
	DEXA SCAN

ULTRASOUND

	Exam
	ABDOMEN COMPLETE
	LIVER / GB / PANCREAS (RUQ)
	KIDNEY / BLADDER
	THYROID
	SCROTAL / TESTICULAR
	PELVIC TRANSABD & TRANSVAG
	CAROTID DOPPLER
	AORTA
	R L B LE ARTERIAL DOPPLER
	R L B LE VENOUS DOPPLER
	UE LE MUSCULOSKELETAL STUDY

PROSTATE MRI

	Exam
	MRI w/wo CONTRAST
	OTHER:

X-RAY

	Options	Exam
		ORBITS for MRI
		CHEST PA & LATERAL
		ABDOMEN KUB (1 view)
	3 5 F/E	CERVICAL SPINE
		THORACIC SPINE
	3 5 F/E	LUMBAR SPINE
		PELVIS
	R L B	HIP
	R L B	KNEE
	R L B	FOOT
	R L B	ANKLE
	R L B	SHOULDER
	R L B	HAND
	R L B	WRIST
	R L B	RIBS
	R L B	HUMERUS
	R L B	ELBOW
	R L B	FOREARM
	R L B	FEMUR
	R L B	TIB - FIB
	R L	FINGER / TOES

CT SCAN

	Options	Exam
	wo w/wo w	BRAIN
	wo	SINUSES
	wo	FACIAL BONES
	w/wo w	NECK SOFT TISSUE
	wo w	CHEST
	w	PE CHEST
	wo w/wo w	ABDOMEN / PELVIS
	wo	RENAL STONE STUDY
	w/wo	CT UROGRAM
		CERVICAL SPINE
		THORACIC SPINE
		LUMBAR SPINE
	R L B	SHOULDER / ELBOW / WRIST
	R L B	HIP / KNEE / ANKLE / FOOT
		3D RECONSTRUCTION
		CT CALCIUM SCORE
		CT ANGIOGRAPHY (CTA)
		CAROTID / NECK CTA
		THORACIC AORTA CTA
		ABDOMINAL AORTA CTA
	R L B LE UE	PERIPHERAL CTA

COMMENTS:

☐ **PRIORITY READING** - Please provide contact telephone number (______________________)