3T Imaging
OF MORTON GROVE

9000 WAUKEGAN ROAD
SUITE #110
MORTON GROVE, IL 60053
(O) (847) 213 2700
(F) (847) 213 2709
www.3Timaging.com

DATE: _____

PATIENT'S NAME: _____

PATIENT'S PHONE#: _____ DOB: _____

PHYSICIAN: _____

CLINICAL HISTORY/INDICATION: _____

Pre-certification: _____

Date: _____

Exp: _____

ICD-10: _____

cc/NAME: _____ FAX NUMBER: _____

PHYSICIAN'S SIGNATURE: _____

If clinical decision support (CDS) software utilized, please specify vendor and approval: _____

PERTINENT CLINICAL DIAGNOSIS REQUIRED

PLEASE PROVIDE SPECIFIC ICD-10 CODES AND WHEN POSSIBLE: SYMPTOMS, LOCATION, DURATION, AND PERTINENT PAST HISTORY. (PLEASE DO NOT USE "RULE OUT", "POSSIBLE", ETC.)

COMMENTS: _____

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

☐ With Contrast ☐ Without Contrast ☐ With and Without Contrast ☐ On-site BUN/Cr testing if needed

MRI

BRAIN / NEURO

- ☐ BRAIN (ROUTINE)
- ☐ PITUITARY ☐ ORBITS
- ☐ IAC'S
- MRI NECK (SOFT TISSUE)
- MRA BRAIN (CIRCLE OF WILLIS)
- MRA NECK (CAROTIDS)

SPINE ☐ CERVICAL ☐ THORACIC ☐ LUMBAR ☐ SACRUM

EXTREMITIES

- R L SHOULDER ☐ with arthrogram
- R L HUMERUS
- R L ELBOW ☐ with arthrogram
- R L FOREARM
- R L WRIST ☐ with arthrogram
- R L HAND
- R L HIP ☐ with arthrogram
- R L FEMUR
- R L KNEE ☐ with arthrogram
- R L LEG (TIBIA/FIBULA)
- R L ANKLE/HINDFOOT
- R L FOREFOOT

ABDOMEN / CHEST

- ☐ LIVER ☐ MRCP
- ☐ PANCREAS
- ☐ RENAL
- ☐ CHEST
- ☐ OTHER: _____
- ☐ MRA: _____

PELVIS

- ☐ BONY ☐ SI JOINTS
- ☐ UTERUS/OVARIES
- ☐ PROSTATE
- ☐ HERNIA PROTOCOL
- ☐ SOFT TISSUE SPECIFY

WOMEN'S IMAGING

SCREENING MAMMOGRAPHY (CHECK ALL THAT APPLY)
- ☐ ANNUAL (NO SYMPTOMS)
- ☐ IF INDICATED, MAY ADD DIAGNOSTIC VIEWS AND/OR ULTRASOUND

DIAGNOSTIC MAMMOGRAPHY WITH ULTRASOUND IF MEDICALLY INDICATED
☐ B ☐ R ☐ L ☐ MAY ADD R/L PRN

BREAST ULTRASOUND ☐ BILATERAL ☐ R ☐ L
☐ W MAMMOGRAPHY IF INDICATED

BREAST MRI W/WO PLEASE CALL

☐ **BONE DENSITY (DEXA)**

ULTRASOUND

- 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 with Dr. B. Kincaid

SPECIFY:

X-RAY

- ORBITS for MRI
- CHEST PA & LATERAL
- ABDOMEN ☐ SUPINE ☐ SUPINE / UPRIGHT
- PELVIS
- 3 5 F/E CERVICAL SPINE
- THORACIC SPINE
- 3 5 F/E LUMBAR SPINE
- SCOLIOSIS
- BONE AGE (L HAND)

JOINTS AND EXTREMITIES SPECIFY

R L B

R L B

R L B

X-RAY OTHER:

CT SCAN

- BRAIN
- SINUSES
- FACIAL BONES
- NECK SOFT TISSUE
- IAC's / TEMPORAL BONE
- CHEST
- SCREENING CHEST (LDCT) wo
- PE CHEST CTA
- ABDOMEN / PELVIS
- RENAL STONE STUDY wo
- CT UROGRAM w/wo
- CERVICAL SPINE
- THORACIC SPINE
- LUMBAR SPINE
- CT MYELOGRAPHY
- R L SHOULDER / ELBOW / WRIST
- R L HIP / KNEE / ANKLE / FOOT
- CT CALCIUM SCORE

CT ANGIOGRAPHY (CTA) w contrast
- ☐ CTA HEAD
- ☐ CTA CAROTID / NECK
- ☐ PULMONARY CTA
- ☐ CTA THORACIC AORTA
- ☐ CTA ABDOMINAL AORTA
- ☐ CTA AORTA & LOW EXT RUNOFF

OTHER

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