St. Paul Radiology
Imaging and Radiology Services

Appt. Date and Time

Patient Contact #

Authorization #

APPOINTMENT SCHEDULING

651.632.5700 *phone* **651.632.5701** *fax*

❑ Downtown
❑ Maplewood

PREPARATION INFORMATION

Please arrive ❑ 15 Min ❑ 45 Min ❑ 60 Min before your scheduled exam time

❑ No preparation needed
❑ Nothing to eat or drink ____ before exam
❑ Stop taking anticoagulant medication as directed by physician
❑ Will need a taxi
❑ Follow these instructions: _____

Patient DOB

Reason for Exam

Indications/Symptoms

Referring Physician *(Please Print)*

Referring Physician Signature

If available, please fax a copy of patient's most recent insurance card with this order.

MRI

❑ Head:
___ Routine
___ Spectroscopy
___ Stereotactic
❑ Orbit/Face/Sinus
❑ Pituitary
❑ IAM's
❑ Soft Tissue Neck
❑ TMJ
❑ Cervical Spine
❑ Thoracic Spine
❑ Lumbosacral Spine
❑ Chest
❑ Abdomen/Pelvis Elastography
❑ Abdomen/Pelvis Enterography
❑ Abdomen/Kidneys
❑ Pelvis
❑ Hips R L
❑ Knee R L
❑ Ankle R L
❑ Shoulder R L
❑ Elbow R L
❑ Wrist R L
❑ Brachial Plexus R L
❑ Other: _____

MR ANGIOGRAPHY

❑ Head: ___ Arterial ____Venous
❑ Neck
❑ Other: _____

MR ARTHROGRAM

❑ Joint
❑ List Joint: _____

X-RAYS

❑ Specify: _____
_____

CT

❑ Head
❑ Orbits
❑ Facial Bones/Jaw
❑ Sinuses: __ Routine __ Limited
❑ Temporal Bones/Mastoids
❑ Soft Tissue Neck
❑ Cervical Spine
❑ Thoracic Spine
❑ Lumbosacral Spine
❑ Chest:
__ Routine __ High Res __ PE
❑ Abdomen and Pelvis:
__ Routine __ Kidney Stone
❑ Hematuria (without delays)
❑ CT/Urogram
❑ Abdomen Only
❑ Pelvis Only
❑ Hips
❑ Extremity: _____
❑ CT Colonography - Failed Colonoscopy
❑ Other: _____

CT ANGIOGRAPHY INCLUDING 3D

❑ Head
❑ AAA Stent Graft
❑ Other: _____

CT STEALTH INCLUDING 3D

❑ __ Head __ Sinus __ Lumbosacral Spine

PET

❑ Whole Body
❑ Head
❑ Cardiac

PREVENTATIVE SCREENINGS

❑ Low-Dose Lung CT
❑ Heart
❑ Colon
❑ Other : _____

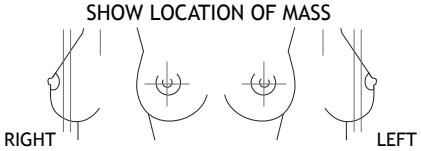
ULTRASOUND

❑ Abdomen
❑ Pelvis
❑ OB Fetal Survey (Complete)
❑ OB Before 14 Weeks
❑ OB Biophysical Profile
❑ OB Growth Check (Limited)
❑ Hysterosonogram
❑ Aorta
❑ Carotid
❑ Renal
❑ Scrotum/Testicles
❑ Thyroid
❑ Venous: Leg: R L Both
Arm: R L Both
❑ Arterial: Leg: R L Both
Arm: R L Both
❑ Other: _____

BREAST

❑ Screening Mammogram
❑ Diagnostic Mammogram
❑ MRI
❑ Ultrasound Breast
❑ Ultrasound Guided Cyst Aspiration
❑ Ultrasound Guided Core Biopsy

SHOW LOCATION OF MASS



SIZE OF MOST IMPORTANT MASS (CM)	RIGHT	CM
	LEFT	CM

PAIN MANAGEMENT

❑ Epidural Steroid Injection
❑ Other (Level): _____

BONE DENSITOMETRY

❑ Bone Densitometry (Dexa Scan)

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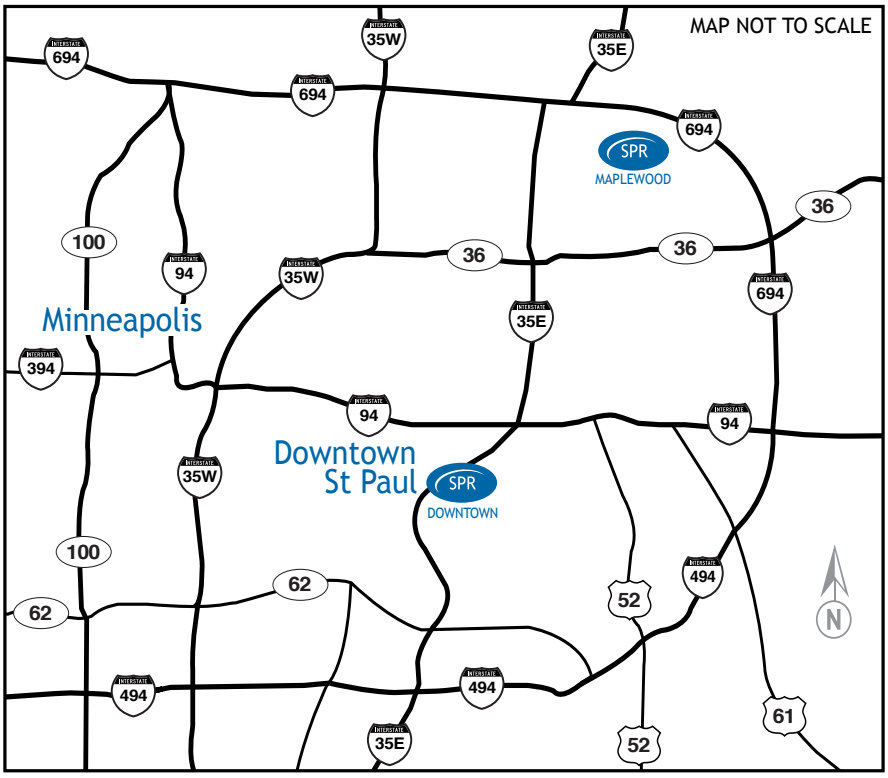
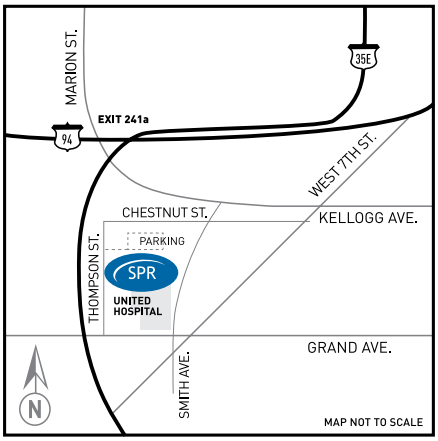
The **Name** you trust.
The **Value** you deserve.



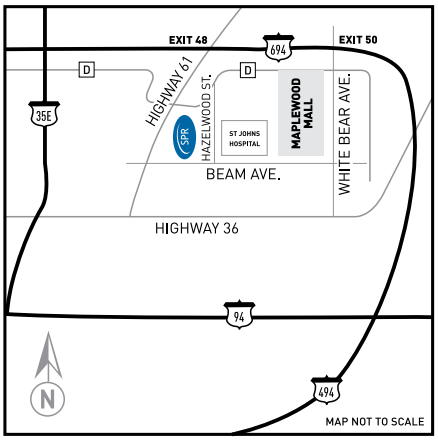
For detailed directions to each imaging center, please visit our website at
stpaulradiology.com/contact/imaging-centers



DOWNTOWN

250 Thompson Street
St. Paul, MN 55102

Phone #: 651.602.7200



MAPLEWOOD

2945 Hazelwood Street North, Suite 110
Maplewood, MN 55109

Phone #: 651.747.4500