

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> MILWAUKEE
7818 W. Layton Ave.
Greenfield, WI 53220
P 414.281.1490
F 414.281.1491 | <input type="checkbox"/> KENOSHA
1020 35th St.
Suite 120
Kenosha, WI 53140
P 262.842.1400
F 262.842.1401 | <input type="checkbox"/> RACINE
6800 Washington Ave.
Suite B
Racine, WI 53406
P 262.321.7970
F 262.321.7995 | <input type="checkbox"/> MADISON
2277 Deming Way
Middleton, WI 53562
P 608.829.8299
F 608.829.8290 |
|--|--|---|---|

Appt Date/Time:

Patient Name (as shown on insurance card)	Cell Phone	Home Phone
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Patient DOB	<input type="checkbox"/> M <input type="checkbox"/> F	Insurance Type - please fax copy of card(s) <input type="checkbox"/> Private <input type="checkbox"/> Government <input type="checkbox"/> L&I/Workers' Comp <input type="checkbox"/> Auto <input type="checkbox"/> No Insurance
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(REQUIRED) Written Diagnosis/Reason/Symptom for Exam(s). Must include **specific** clinical indications (such as location, context and severity)

Previous Treatments/Imaging/Exams No Yes Type _____ Where _____

Patient Considerations (check all that apply) Special assistance required Allergies to contrast agents Diabetes Weight consideration

Interpreter Needed (language) _____ Renal Failure/Dialysis Claustrophobic Sedation (administered by MH Imaging)

Other _____ All patients receiving sedation require a driver.

REPORTING METHOD: Routine Next Day Follow-up Read & Call Patient to Hand Carry Report Only

STAT MH Imaging Web Portal **Fax report to:**

Provider Name (Print)	Provider Location	Phone
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Provider Signature (Required)	Date
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MRI

- | | | |
|---|--|--|
| <input type="checkbox"/> Brain
<input type="checkbox"/> Brainreader™
<input type="checkbox"/> Brain & IAC
<input type="checkbox"/> Brain & Pit
<input type="checkbox"/> Brain & Orbits
<input type="checkbox"/> Brain & CN
<input type="checkbox"/> Brain w/ Diffusion Weighted Imaging
<input type="checkbox"/> Breast
<input type="checkbox"/> Chest
<input type="checkbox"/> Finger
<input type="checkbox"/> Toe
<input type="checkbox"/> Parotid Gland
<input type="checkbox"/> TMJ
<input type="checkbox"/> Soft Tissue Neck
<input type="checkbox"/> C Spine
<input type="checkbox"/> T Spine
<input type="checkbox"/> L Spine
<input type="checkbox"/> Total Spine (scoliosis)
<input type="checkbox"/> Scoliosis Spine Survey | <div style="border:1px solid black; padding:2px; width:fit-content; margin:auto;"> With Contrast
 <input type="checkbox"/> Yes <input type="checkbox"/> No </div> | <input type="checkbox"/> Shoulder L R
<input type="checkbox"/> Elbow L R
<input type="checkbox"/> Wrist L R
<input type="checkbox"/> Hand L R
<input type="checkbox"/> Hip L R
<input type="checkbox"/> Knee L R
<input type="checkbox"/> Ankle L R
<input type="checkbox"/> Foot L R
<input type="checkbox"/> Pelvis
<input type="checkbox"/> Prostate
<input type="checkbox"/> Female Pelvis
<input type="checkbox"/> Abdomen
<input type="checkbox"/> Abdomen/Pancreas
<input type="checkbox"/> Abdomen/Adrenal Glands
<input type="checkbox"/> Abdomen/Kidneys
<input type="checkbox"/> Abdomen/MRCP
<input type="checkbox"/> Enterography
<input type="checkbox"/> Other _____ |
|---|--|--|

CT

- | | |
|--|--|
| <input type="checkbox"/> Brain w/o
<input type="checkbox"/> Brain w/w
<input type="checkbox"/> IAC w/o
<input type="checkbox"/> IAC w/w
<input type="checkbox"/> Sinus w/o
<input type="checkbox"/> Sinus w/w
<input type="checkbox"/> TMJ w/o
<input type="checkbox"/> Orbits w/o
<input type="checkbox"/> Orbits w/w
<input type="checkbox"/> Soft Tissue Neck w/o
<input type="checkbox"/> Soft Tissue Neck w
<input type="checkbox"/> C Spine w/o
<input type="checkbox"/> C Spine w
<input type="checkbox"/> T Spine w/o
<input type="checkbox"/> T Spine w
<input type="checkbox"/> L Spine w/o
<input type="checkbox"/> L Spine w
<input type="checkbox"/> Discogram | <input type="checkbox"/> Calcium Score
<input type="checkbox"/> Chest w/o
<input type="checkbox"/> Chest w
<input type="checkbox"/> Chest w/w (high resolution for interstitial disease)
<input type="checkbox"/> Abdomen w/o
<input type="checkbox"/> Abdomen w
<input type="checkbox"/> Abdomen w/w
<input type="checkbox"/> Abdomen Pelvis w/o
<input type="checkbox"/> Abdomen Pelvis w
<input type="checkbox"/> Abdomen Pelvis w/w
<input type="checkbox"/> Urogram w/w
<input type="checkbox"/> Abdomen Pelvis Stone Protocol w/o
<input type="checkbox"/> Pelvis w/o
<input type="checkbox"/> Pelvis w
<input type="checkbox"/> CT Enterography w/o
<input type="checkbox"/> CT Enterography w
<input type="checkbox"/> Extremity Joint _____
<input type="checkbox"/> Other _____ |
|--|--|

MRA

- | | | |
|---|--|---|
| <input type="checkbox"/> Head w/o
<input type="checkbox"/> Neck
<input type="checkbox"/> Thoracic Aorta w/w
<input type="checkbox"/> Abdominal Aorta w/w
<input type="checkbox"/> Renal Aorta w/w
<input type="checkbox"/> SMA w/w
<input type="checkbox"/> IVC w/w
<input type="checkbox"/> Chest | <div style="border:1px solid black; padding:2px; width:fit-content; margin:auto;"> With Contrast
 <input type="checkbox"/> Yes <input type="checkbox"/> No </div> | <input type="checkbox"/> Lower Extremity
<input type="checkbox"/> Upper Extremity
<input type="checkbox"/> Subclavian
<input type="checkbox"/> Other _____ |
|---|--|---|

CTA

- | | |
|---|---|
| <input type="checkbox"/> Head w
<input type="checkbox"/> Neck w
<input type="checkbox"/> Thoracic Aorta w
<input type="checkbox"/> Pulmonary w
<input type="checkbox"/> Abdominal Aorta w
<input type="checkbox"/> SMA w
<input type="checkbox"/> IVC w
<input type="checkbox"/> Abdominal/Pelvic/Lower extremities w
<input type="checkbox"/> CTCA _____ | <input type="checkbox"/> Head w/o
<input type="checkbox"/> Neck w/o
<input type="checkbox"/> Thoracic Aorta w/o
<input type="checkbox"/> Pulmonary w/o
<input type="checkbox"/> Abdominal Aorta w/o
<input type="checkbox"/> SMA w/o
<input type="checkbox"/> IVC w/o
<input type="checkbox"/> Abdominal/Pelvic/Lower extremities w/o
<input type="checkbox"/> CTCA _____ |
|---|---|

CANCER SCREENING

MRI CT Ultrasound Region _____

MYELOGRAM

C Spine T Spine L Spine

CSF Labs Desired? Y N

List Labs: _____

ECHOCARDIOGRAM

Echocardiogram*

**Echocardiograms read by Board Certified Cardiologist*

ARTHROGRAM CT MRI

Shoulder R L Wrist R L Elbow R L Knee R L Hip R L Ankle R L

X-RAY

- | | |
|---|--|
| <input type="checkbox"/> Chest PA
<input type="checkbox"/> Chest PA & LAT
<input type="checkbox"/> Soft Tissue Neck
<input type="checkbox"/> Abdominal Series <input type="checkbox"/> Abdominal KUB
<input type="checkbox"/> Ribs <input type="checkbox"/> Unilateral <input type="checkbox"/> Bilateral
<input type="checkbox"/> w/ chest <input type="checkbox"/> w/o chest
<input type="checkbox"/> Pelvis
<input type="checkbox"/> C Spine Ap & Lateral
<input type="checkbox"/> C Spine Complete
<input type="checkbox"/> T Spine Complete
<input type="checkbox"/> L Spine Ap & Lateral
<input type="checkbox"/> L Spine Complete
<input type="checkbox"/> Sacrum/Coccyx
<input type="checkbox"/> SI Joints
<input type="checkbox"/> Hip L R
<input type="checkbox"/> Femur L R
<input type="checkbox"/> Knees L R
<input type="checkbox"/> TIB/FIB L R
<input type="checkbox"/> Ankle L R
<input type="checkbox"/> Foot L R
<input type="checkbox"/> Toes _____ | <input type="checkbox"/> Skull
<input type="checkbox"/> Facial Bones
<input type="checkbox"/> Sinus
<input type="checkbox"/> Mandible
<input type="checkbox"/> Scoliosis Series
<input type="checkbox"/> Flexion/Extension
<input type="checkbox"/> Flexion/Extension
<input type="checkbox"/> Flexion/Extension
<input type="checkbox"/> Flexion/Extension
<input type="checkbox"/> Shoulder L R
<input type="checkbox"/> Humerus L R
<input type="checkbox"/> Elbow L R
<input type="checkbox"/> Forearm L R
<input type="checkbox"/> Wrist L R
<input type="checkbox"/> Fingers _____
<input type="checkbox"/> Other _____ |
|---|--|

ULTRASOUND

- | | |
|--|---|
| <input type="checkbox"/> ABI, Levels _____ include
Toe Pressure _____
<input type="checkbox"/> Abdomen Complete
<input type="checkbox"/> Aorta
<input type="checkbox"/> Appendix
<input type="checkbox"/> Biophysical Profile
<input type="checkbox"/> Breast R L Bilateral
<input type="checkbox"/> Breast Limited 1-3 Quadrants
R L Bilateral
<input type="checkbox"/> Carotid Duplex
<input type="checkbox"/> Echocardiogram
<input type="checkbox"/> OB Ultrasound
<input type="checkbox"/> 1st Trimester with
Transvaginal as needed
<input type="checkbox"/> 2nd Trimester
<input type="checkbox"/> 3rd Trimester
<input type="checkbox"/> Gallbladder (GB, Panc, Liver) | <input type="checkbox"/> Hernia
Location _____
<input type="checkbox"/> OB Ultrasound Follow Up (check growth)
<input type="checkbox"/> OB Ultrasound Limited
<input type="checkbox"/> Pediatric Hips
<input type="checkbox"/> Renal (Kidneys and Bladder)
<input type="checkbox"/> Pelvic Ultrasound with
Transvaginal as needed
<input type="checkbox"/> Renal Artery Study
<input type="checkbox"/> Soft Tissue Mass Area _____
<input type="checkbox"/> Testicular
<input type="checkbox"/> Thyroid
<input type="checkbox"/> Venous Doppler
<input type="checkbox"/> Lower Ext. R L Bilateral
<input type="checkbox"/> Upper Ext. R L Bilateral
<input type="checkbox"/> Other _____ |
|--|---|

PATIENT INSTRUCTIONS: *Preparing For Your Exam*

MRI

- ❑ Creatinine levels may be required for any patient over the age of 60, and all patients being treated for renal disease, diabetes, or hypertension.
- ❑ **No prep for MRI exams.** MRI cannot be performed on patients with a Cardiac Pacemaker, some Cardiac Valves and Stents, Otologic implants, implanted neurostimulator, non-titanium aneurysm clips in head, Pregnancy (In some cases). Please bring any relevant outside X-rays or other exams for correlation. This is especially important for Spine and Musculoskeletal MRI Exams.

CT

- ❑ Creatinine levels may be required for any patient over the age of 40, and all patients being treated for renal disease, diabetes or hypertension.
- ❑ **Abdomen:** No food 5 hours prior - may drink fluids. Arrive 60 minutes early to begin drinking contrast.
- ❑ **Chest:** No food 5 hours prior, bring recent Chest X-Rays for correlation and planning.
- ❑ **Pelvis:** No food 5 hours prior, may drink fluids. Arrive 1 hour early to begin drinking contrast.
- ❑ **Exam: w/ IV Contrast:** No food 5 hours prior - may drink fluids. Arrive 1 hour early to begin drinking contrast. Creatinine levels are required for patients over 65.
- ❑ **All Other CT Exams:** No preparation necessary, unless advised.

WELLNESS SCREENING

No preparation necessary, unless advised.

ULTRASOUND

EXAM	PREP
Abdomen Complete:	NPO for 8 - 10 hours. Includes no smoking or chewing gum.
Abdominal Doppler:	NPO for 8 - 10 hours.
Aorta:	NPO for 8 - 10 hours.
Appendix:	Full urinary bladder
Breast:	NO Prep
Carotid:	NO Prep
Gallbladder:	NPO for 8 - 10 hours
Guided Biopsy:	NPO 4 - 6 hours prior to study. Recent PT & PTT needed.
Fluid Localization:	Consent for procedure.
Liver/Spleen/Pancreas:	NPO 8 - 10 hours
Pelvic:	Full urinary bladder. Drink 1 quart of water 1 hour prior.
Renal:	No carbonated beverages. 12 oz H2O 1/2 hour prior.
Testicular:	No Prep
Thoracentesis:	Consent for procedure.
Thyroid:	No Prep
Transvaginal:	Empty urinary bladder
Venous:	Hydrate

Note: Patients who are diabetic should be scheduled accordingly. As early as allowable if they have dietary restrictions.

W Forest Garden Ct
W Forest Home Ave
W Layton Ave
S 81st St
Sendik's Food Market
7818 W. Layton Ave., Greenfield, WI 53220

13th Ave
14th Ave
33rd St
35th St
Sheridan Rd
KENOSHA
1020 35th St., Suite 120, Kenosha, WI 53140

Lindermann Ave
Warwick Way
Washington Ave
RACINE
6800 Washington Ave., Suite B, Racine, WI 53406

Deming Way
Costco
Donna Dr
Middleton
MADISON
2277 Deming Way, Middleton, WI 53562