PLEASANTON
DIAGNOSTIC IMAGING CENTER

4211 Rosewood Dr. #5
Pleasanton, CA 94588
Phone: 925-467-1400
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OUTPATIENT REQUISITION
Please complete ALL sections
Tax ID #: 45-1497338

ALL INFORMATION PROVIDED IS FOR THE CARE OF THE PATIENT ☐ **Stat Report**

Patient Name: ______________________ DOB: ____________ Today's Date: ____________
Patient consented contact #: ______________ **Can message be left at this #? Yes No ☐ **Call Patient To Schedule**
Referring Physician (Name): ______________ Referring Physician (Signature): ______________
Physician phone #: ______________________
Insurance Company: ______________________ Authorization Number: ______________
☐ Fax Appt. Confirmation: Fax # ______________ ☐ Stat Reading: Call / page / Fax # ______________ (Please circle preference)
☐ Patient To Carry CD images ☐ Patient To Carry Films ☐ Deliver Films To: ______________
CC Physician: ______________________

Clinical History **(CPT Code/ICD-9)**: ______________________
Special requests/Instructions: ______________________

Complete for CT & MRI (Exception CT Spines): ***Cardiovascular Disease*** ☐ Yes ☐ No
Age > 60 ☐ Yes ☐ No ***Renal Disease*** ☐ Yes ☐ No ***Diabetic*** ☐ Yes ☐ No ***Metformin*** ☐ Yes ☐ No
If yes to 1 or more, a creatine level drawn within the past 30 Days must be provided.
Creatinine level: ________, ***Date drawn:*** ____________ ***eGFR:*** ________

CT – I.V. Contrast will be decided upon by Radiologist unless otherwise specified

*CT

☐ ***With Contrast*** ☐ ***Without Contrast*** ☐ ***With and Without Contrast***

- ☐ Brain
- ☐ Neck (soft tissues)
- ☐ Chest
- ☐ Abdomen (does not include pelvis unless pelvis also ordered)
  - *Optional organ-focused:*
  - ☐ *Liver*[3] ☐ *Pancreas*[3] ☐ *Kidney*[3] ☐ *Adrenal*[3]
- ☐ Pelvis
- ☐ Facial Bones
- ☐ Orbits
- ☐ Temporal Bones
- ☐ Sinus
- ☐ Spine: ☐ Cervical ☐ Thoracic ☐ Lumbar
- ☐ Extremity: ______________
- ☐ OTHER: ______________

CT - SPECIALIZED EXAMINATIONS

- ☐ Kidney Stone[1] (for urinary tract calculi includes KUB)
- ☐ Enterography[2] (replaces SBFT for most Indications)
- ☐ Hematuria/CT IVP[3] (w/u of painless hematuria Inct. 3D)
- ☐ High Res Chest[1] (diffuse pulmonary disease)
- ☐ Chest for Pulmonary Embolus[3]
- ☐ Lung Cancer Screening[1] (Self Pay)

CTA

☐ Head ☐ Neck ☐ Chest ☐ Abdomen

MAMMOGRAPHY

- ☐ Screening* ☐ R ☐ L ☐ Bilateral
- ☐ Diagnostic ☐ R ☐ L ☐ Bilateral

DEXA

- ☐ DEXA Bone Densitometry
- ☐ Vertebral Fracture Assessment

MRI

☐ ***With Contrast*** ☐ ***Without Contrast*** ☐ ***Per Radiologist***

- ☐ Brain ☐ IAC ☐ Orbits ☐ Pituitary
- ☐ Neck (soft tissues)
- ☐ MRCP
- ☐ Pelvis Soft Tissue ☐ Pelvis R/O fracture
- ☐ Brachial Plexus ☐ R ☐ L ☐ Bilateral
- ☐ Spine ☐ Cervical ☐ Thoracic ☐ Lumbar
- ☐ Knee ☐ R ☐ L
- ☐ Shoulder ☐ R ☐ L
- ☐ Extremity ☐ R ☐ L ______________
- ☐ OTHER: ______________

WALK-IN X-RAY

- ☐ Chest ☐ 1 View ☐ 2 View
- ☐ Abdomen ☐ KUB ☐ 3 View
- ☐ Pelvis
- ☐ IVP
- ☐ Ribs ☐ R ☐ L ☐ Bilateral
- ☐ Hip ☐ R ☐ L ☐ Bilateral
- ☐ Knee ☐ R ☐ L ☐ Bilateral
- ☐ Ankle ☐ R ☐ L ☐ Bilateral
- ☐ Foot ☐ R ☐ L ☐ Bilateral
- ☐ Shoulder ☐ R ☐ L ☐ Bilateral
- ☐ Elbow ☐ R ☐ L ☐ Bilateral
- ☐ Wrist ☐ R ☐ L ☐ Bilateral
- ☐ Hand ☐ R ☐ L ☐ Bilateral
- ☐ Spine: ☐ Cervical ☐ Thoracic ☐ Lumbar
  - ☐ *Standard 3 View* ☐ *With Obliques*
- ☐ Sinuses ☐ *Single Waters View* ☐ *Full Series*
  - ☐ OTHER: ______________

MRA

- ☐ Renal Arteries
- ☐ Head
- ☐ Carotid Arteries w/contrast

ULTRASOUND

- ☐ Abdomen Complete
- ☐ Abdomen Limited: Specify Quad ________
- ☐ Aorta
- ☐ Appendix/right lower quadrant
- ☐ AAA (Screening)
- ☐ Breast
  - ☐ Right ☐ Left ☐ Bilateral
- ☐ Carotid Duplex Bilateral
- ☐ Lower Extremity Venous Duplex
  - ☐ Right ☐ Left ☐ Bilateral
- ☐ Obstetrical
  - a. Biophysical Profile
  - b. First Trimester (with endovaginal study)
  - c. Second/Third Trimester Complete
- ☐ Pelvic/Gyn (with endovaginal and doppler study, as specified)
- ☐ Portal/Hepatic Vascular Duplex Study
- ☐ Retroperitoneal/Renal/Bladder
- ☐ Saphenous Vein Mapping
- ☐ Scrotum/Testicles with arterial/ Venous evaluation
- ☐ Soft Tissue
  - a. Abdomen/Thorax/Extremity
  - b. Head/Neck
- ☐ Thyroid
- ☐ Upper Extremity Venous Duplex
  - ☐ Right ☐ Left ☐ Bilateral
- ☐ OTHER: ______________

[1]without contrast [2]with contrast [3]without and with contrast

Date: ______________ At: ____________ A.M. / P.M. Location: ______________________

554-7140-02 (04/14)