☐ 43731 15th Street West
LANCASTER, CA 93534
Tel: (661) 949-8111
Fax: (661) 949-6600

☐ 607 West Ave Q
PALMDALE, CA 93551
Tel: (661) 456-2020
Fax: (661) 456-2021

ADVANCED IMAGING CENTER

www.advanced-imaging-center.com

☐ 900 Heritage Drive, Bldg. B
RIDGECREST, CA 93555
Tel: (760) 446-1999
Fax: (760) 446-1910

☐ 25842 Tournament Road
VALENCIA, CA 91355
Tel: (661) 255-0060
Fax: (661) 255-0024

REQUISITION FORM

PATIENT INFORMATION
Name:______________________ DOB:____________
Phone: (home)________________ (cell) ____________
Diagnosis/Symptoms:______________________________
____

PHYSICIAN INFORMATION
Referring Physician:______________________________
Phone:______________Fax:__________________
Contact Person____________________Ext:__________
Appointment Date & Time:__________________________

☐ STAT
☐ Fax Preliminary Report (Fax #________________)
☐ Call Results (Phone # ________________)
☐ Request CD
☐ Request Films

CC: ______________________________

MRI / MRA

☐ **With Contrast**
☐ **Without Contrast**
☐ **Radiologist's Discretion**
☐ Brain
☐ Pituitary
☐ Orbits
☐ Face
☐ IAC's
☐ Soft Tissue Neck
☐ Cervical Spine
☐ Thoracic Spine
☐ Lumber Spine
☐ Abdomen
☐ Pelvis
☐ Hip ☐ R ☐ L ☐ B
☐ Shoulder ☐ R ☐ L ☐ B
☐ Arm ☐ R ☐ L ☐ B
☐ Wrist ☐ R ☐ L ☐ B
☐ Knee ☐ R ☐ L ☐ B
☐ Leg ☐ R ☐ L ☐ B
☐ Ankle ☐ R ☐ L ☐ B
☐ Foot ☐ R ☐ L ☐ B
☐ Other______________

MR Angiogram
☐ Brain
☐ Pulmonary
☐ Carotid
☐ Renal
☐ Runoff
☐ Other______________

MR Athrogram
☐Shoulder ☐ R ☐ L ☐ B
☐ Knee ☐ R ☐ L ☐ B
☐ Wrist ☐ R ☐ L ☐ B
☐ Ankle ☐ R ☐ L ☐ B
☐ Elbow ☐ R ☐ L ☐ B
☐ Ankle ☐ R ☐ L ☐ B
☐ Other______________

CT / CTA

☐ **With Contrast**
☐ **Without Contrast**
☐ **Radiologist's Discretion**
☐ Brain
☐ Temporal Bones/IAC's
☐ Orbits
☐ Sinuses
☐ Soft Tissue Neck
☐ Cervical Spine
☐ Thoracic Spine
☐ Lumber Spine
☐ Chest
☐ Abdomen
☐ Pelvis
☐ Urogram
☐ Other______________
____

CT Angiogram
☐ Head
☐ Carotid
☐ Chest (Pulmonary)
☐ Coronary
☐ Renal
☐ Runoff
☐ Abdomen
☐ Pelvis
☐ Other______________
____

☐ **CT Guided Biopsy**
Specify Body Part:
____

NUCLEAR MED

☐ **Add SPECT (enhances bone definition)**
☐ Whole Body Bone Scan
☐ Three Phase Bone Scan (Region:__________)
☐ Thyroid Uptake
☐ Thyroid Scan:______________
☐ HIDA Scan
☐ Indium Scan
☐ Other______________
____

PET - CT
☐ **With Contrast**
☐ **Without Contrast**
☐ **Radiologist's Discretion**
☐ Whole Body
☐ Brain
☐ Diagnostic
☐ Staging
☐ Restaging
Specify Indication:______________
____
____
☐ Other______________
____

HEALTH SCAN

☐ Total Body Scan
☐ Coronary Calcium Scoring
☐ Coronary CT Angio
☐ Virtual Colonoscopy

US

☐ **Add Doppler for Vascular Definition**
☐ Carotid ☐R ☐ L ☐ B
☐ Aorta
☐ Renal
☐ Venous
☐R ☐ L ☐ B ☐UE ☐ LE
☐ Arterial
☐R ☐ L ☐ B ☐UE ☐ LE
☐ Scrotum
☐ Abdomen
☐ Pelvis
☐ Gallbladder
☐ OB
☐ Complete ☐ Limited
☐ Thyroid
☐ Soft Tissue__________
☐ US Guided Biopsy
Specify Body Part:
____
☐ Other ______________
____

BREAST IMAGING

Digital Mammography
☐ Screening Mammogram
☐ Diagnostic Mammogram
☐ Explain______________
____
____

☐ **Ultrasound Breast**
☐R ☐ L ☐ B

☐ **MRI Breast**
☐ Implant Protocol
☐ Tumor Protocol w/ Contrast

XRAY

X-RAY
☐ Views ______________
☐ Flexion / Extension Views
☐ Oblique Views

Specify Body Part:
____
____
____

FLUOROSCOPY
☐ Esophagram
☐ Upper GI
☐ Small Bowel
☐ Barium Enema
☐ IVP
☐ Other______________
____
____

BONE DENSITY
☐ DEXA
☐ CT Bone Density (QCT) (Valencia Only)

Additional Notes:____
____