



1420 E. Bradford Parkway Springfield, Missouri 65804
Phone (417) 885-1100 Fax (417) 885-1109

Outpatient Imaging MRI CT Ultrasound EMG/NCV XRAY

Patient Name: _____ Patient DOB: _____

Patient Phone: _____

Date of Exam: _____ Time of Exam: _____ Or, please call patient to schedule

TYPE OF STUDY(IES) REQUESTED: (Please circle) MRI CT Other

- | | | | |
|------------------------|----------------|------------------------|----------|
| _____ Brain | _____ Shoulder | _____ L | _____ R |
| _____ Pituitary / IAC | _____ Elbow | _____ L | _____ R |
| _____ Chest | _____ Wrist | _____ L | _____ R |
| _____ Cervical Spine | _____ Hip | _____ L | _____ R |
| _____ Thoracic Spine | _____ Knee | _____ L | _____ R |
| _____ Lumbar Plexus | _____ Foot | _____ L | _____ R |
| _____ Lumbar Spine | _____ Ankle | _____ L | _____ R |
| _____ Soft Tissue Neck | _____ Humerus | Distal | Proximal |
| _____ Abdomen | _____ Leg | Upper | Lower |
| _____ Pelvis / Sacrum | | | |
| _____ Brachial Plexus | | | |
| _____ MRA _____ | | _____ Arthrogram _____ | |
| _____ EMG/NVC _____ | | _____ XRAY _____ | |

Ultrasound _____

- _____ MRI / CT Study to be performed without contrast
- _____ CT Study to be performed with contrast ORAL IV
- _____ MRI / CT Study to be performed with & without contrast

Diagnosis/Reason for Exam _____

Ordering Physician: _____

Address: _____

Phone: _____ Fax: _____

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