



APPOINTMENT SCHEDULING

1030 North Charles St. • Baltimore, MD 21201
Phone: 410-605-9393 • Fax: 410-605-9397

10840 Little Patuxent Pkwy • Columbia, MD 21044
Phone: 410-740-9393 • Fax: 410-740-9398

All Contrast Studies require BUN and Creatinine from up to 3 months prior to exam.

Appointment Date: _____ **Time:** _____

CD Requested Film Requested

Clinical History/Symptoms: _____ **Physician's Name:** _____

Patient's Name: _____ **Physician's Phone:** _____

Patient's Phone: _____ **Physician's Fax:** _____

Date of Birth: _____ **Physician's Signature:** _____

MRI BALTO.	
<input type="checkbox"/> Without Contrast	<input type="checkbox"/> With & Without Contrast
<input type="checkbox"/> Brain	
<input type="checkbox"/> Orbit/Face/Sinus	
<input type="checkbox"/> Pituitary	
<input type="checkbox"/> IAC	
<input type="checkbox"/> Soft Tissue Neck	
<input type="checkbox"/> Cervical Spine	
<input type="checkbox"/> Thoracic Spine	
<input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Compression w/Axial Load	
<input type="checkbox"/> Brachial Plexus	
<input type="checkbox"/> Breast	
<input type="checkbox"/> Abdomen: <input type="checkbox"/> Kidney <input type="checkbox"/> Adrenal	
<input type="checkbox"/> Pancreas: _____ MRCP	
<input type="checkbox"/> Cardiac MRI: Viability	
<input type="checkbox"/> Extremity	R / L
Specify _____	

MR ANGIOGRAPHY BALTO.	
<input type="checkbox"/> Head:	<input type="checkbox"/> Arterial <input type="checkbox"/> Venous
<input type="checkbox"/> Neck	
<input type="checkbox"/> Chest:	<input type="checkbox"/> Pulmonary <input type="checkbox"/> Arterial
<input type="checkbox"/> Abdomen:	<input type="checkbox"/> Aorta <input type="checkbox"/> Renal
	<input type="checkbox"/> Mesenteric <input type="checkbox"/> Venous
<input type="checkbox"/> Extremity Runoff	
<input type="checkbox"/> Cardiac MRA:	
<input type="checkbox"/> Other	

CT BALTO. / COLUMBIA	
Bun: _____ / Creatinine: _____	Date: _____
<input type="checkbox"/> Without <input type="checkbox"/> With <input type="checkbox"/> With & Without Contrast	
<input type="checkbox"/> Calcium Score Only	
<input type="checkbox"/> Head	
<input type="checkbox"/> Sinuses: _____ Routine _____ Limited	
<input type="checkbox"/> Orbits	
<input type="checkbox"/> Facial Bones/Jaw/TMJ	
<input type="checkbox"/> Temporal Bones/Mastoids	
<input type="checkbox"/> Soft Tissue Neck	
<input type="checkbox"/> Cervical Spine	
<input type="checkbox"/> Thoracic Spine	
<input type="checkbox"/> Lumbar Spine	
<input type="checkbox"/> Chest: _____ Routine _____ PE _____ High Res	
<input type="checkbox"/> Abdomen & Pelvis	
<input type="checkbox"/> Abdomen Only	
<input type="checkbox"/> Pelvis only	
<input type="checkbox"/> Extremity:	
<input type="checkbox"/> Other	

CT ANGIOGRAPHY BALTO. / COLUMBIA	
<input type="checkbox"/> Brain	<input type="checkbox"/> Neck/Carotid
<input type="checkbox"/> Chest	<input type="checkbox"/> Abdomen
<input type="checkbox"/> Coronary CTA – BALTO. ONLY	
<input type="checkbox"/> Other	

ULTRASOUND BALTO. / COLUMBIA	
<input type="checkbox"/> Abdomen: _____ Complete _____ Limited	
<input type="checkbox"/> Pelvis	
<input type="checkbox"/> Transvaginal	
<input type="checkbox"/> OB Complete	<input type="checkbox"/> TV <12 Weeks
	<input type="checkbox"/> ABD <12 Weeks
<input type="checkbox"/> OB with Biophysical Profile	
<input type="checkbox"/> Carotid	
<input type="checkbox"/> Aorta	
<input type="checkbox"/> Thyroid	
<input type="checkbox"/> Renal	<input type="checkbox"/> Bladder
<input type="checkbox"/> Scrotum/Testicles	
<input type="checkbox"/> Venous:	Leg R / L Both
	Arm R / L Both
<input type="checkbox"/> Arterial:	Leg R / L Both
	Arm R / L Both
<input type="checkbox"/> Echo	
<input type="checkbox"/> Other	

PET CT BALTO. / COLUMBIA	
Indication: _____ Diagnosis _____ Staging _____ Restaging	
<input type="checkbox"/> Whole Body PET CT: Chest/ Abd/Pelvis *Need Labs	
<input type="checkbox"/> Cardiac Viability	
<input type="checkbox"/> Brain: Dementia/Alzheimer's	
<input type="checkbox"/> Solitary Pulmonary Nodule	
<input type="checkbox"/> Myocardio Perfusion	
<input type="checkbox"/> Other	

NUCLEAR BALTO.	
<input type="checkbox"/> Cardiac Stress Test: _____ Adeno _____ Treadmill	
<input type="checkbox"/> Bone Scan	<input type="checkbox"/> Three Phase
<input type="checkbox"/> Renal Scan: _____ Captopril _____ Lasix	
<input type="checkbox"/> Hida: _____ CCK	
<input type="checkbox"/> Gastric Emptying	
<input type="checkbox"/> MUGA	
<input type="checkbox"/> Gallium	<input type="checkbox"/> Brain SPECT
<input type="checkbox"/> Liver Spleen	<input type="checkbox"/> Liver SPECT
<input type="checkbox"/> Other	

RADIOLOGY DIAGNOSTIC XRAY COLUMBIA	
Specify _____	

PLEASE BRING THIS PRESCRIPTION, YOUR INSURANCE CARD AND COPY WITH YOU TO YOUR EXAM.