

2020 Court Street  
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 Toll Free 1-800-794-XRAY  
 (9729)

**NOTE: MUST BE FILLED OUT**

**PATIENT NAME** \_\_\_\_\_ **HEIGHT** \_\_\_\_\_ **WEIGHT** \_\_\_\_\_ **M / F** **DOB** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**STUDY REQUESTED 1)** \_\_\_\_\_ **DATE** \_\_\_\_\_  
**IF NOT BELOW**  
 2) \_\_\_\_\_  
 3) \_\_\_\_\_

**HISTORY / SIGNS / SYMPTOMS** \_\_\_\_\_ **CLAUSTROPHOBIC**

**POOR KIDNEY FUNCTION**

**REQUESTED BY** \_\_\_\_\_ **CC:** \_\_\_\_\_ **ALLERGY TO CONTRAST**

**PHONE REPORT**     **STAT REPORT**     **FAX REPORT**     **PATIENT TO RETURN WITH X-RAYS AND REPORT**

**ATTN. PATIENT: PLEASE BRING THIS FORM, YOUR HEALTH INSURANCE INFORMATION & CARDS WITH YOU**

All exams listed below require an appointment.  
 Please follow the exam instructions exactly as listed on the back. Please call if you have questions.

RADIOLOGY		VASCULAR ULTRA SOUND		<input type="checkbox"/>	Sinus - Complete
<input type="checkbox"/>	Arthrogram w/CT _____	<input type="checkbox"/>	Carotid Doppler	<input type="checkbox"/>	Sinus - Limited
<input type="checkbox"/>	Arthrogram w/MRI _____	<input type="checkbox"/>	Dialysis Graft	<input type="checkbox"/>	Temporal Bones w/o Contrast
<input type="checkbox"/>	Bone Density <input type="checkbox"/> With IVA <input type="checkbox"/> Without IVA	<input type="checkbox"/>	Mesenteric Doppler	<input type="checkbox"/>	Thoracic Spine
<input type="checkbox"/>	Bone Survey	<input type="checkbox"/>	Peripheral Arterial Doppler <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Both	<input type="checkbox"/>	Urogram
<input type="checkbox"/>	Cystogram	<input type="checkbox"/>	Peripheral Venous Doppler for DVT <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Both	<b>CT ANGIOGRAM</b>	
<input type="checkbox"/>	Esophagram	<input type="checkbox"/>	Portal Doppler	<input type="checkbox"/>	CT Angio - Abdomen and Pelvis
<input type="checkbox"/>	GI Series	<input type="checkbox"/>	Renal Artery Doppler	<input type="checkbox"/>	CT Angio - Abdominal Aorta w/Runoff
<input type="checkbox"/>	GI with Small Bowel	<input type="checkbox"/>	TIPS Doppler	<input type="checkbox"/>	CT Angio - Abdomen Renal/Mesenteric
<input type="checkbox"/>	Hysterosalpingogram	<b>BREAST IMAGING</b>		<input type="checkbox"/>	CT Angio - Carotid
<input type="checkbox"/>	X-Ray _____	<input type="checkbox"/>	Mammogram - Screening	<input type="checkbox"/>	CT Angio - Chest
<input type="checkbox"/>	Leg Length (Scanogram)	<input type="checkbox"/>	Mammogram - Diagnostic	<input type="checkbox"/>	CT Angio - Coronary
<input type="checkbox"/>	Lumbar Puncture	<input type="checkbox"/>	Ultrasound Breast: <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/>	CT Angio - Head
<input type="checkbox"/>	Myelogram/CT _____	<input type="checkbox"/>	Breast Sonocore Biopsy	<input type="checkbox"/>	CT Angio - Renal
<input type="checkbox"/>	Retrograde Urethrogram	<input type="checkbox"/>	Stereotactic Breast Biopsy	<b>MRI / OPEN MRI</b>	
<input type="checkbox"/>	Small Bowel Follow Through	<input type="checkbox"/>	Breast/Cyst Aspiration	<input type="checkbox"/>	<input type="checkbox"/> W/O IV CONTRAST <input type="checkbox"/> W&W/O IV CONTRAST
<input type="checkbox"/>	Therapeutic Injection/Aspiration	<input type="checkbox"/>	Galactogram	<input type="checkbox"/>	Abdomen
<input type="checkbox"/>	Tomogram _____ site	<input type="checkbox"/>	Breast Localization/J-Wire	<input type="checkbox"/>	Cervical Spine
<input type="checkbox"/>	Voiding Cystourethrogram	<input type="checkbox"/>	<input type="checkbox"/> Sonoguided <input type="checkbox"/> Mammographic	<input type="checkbox"/>	Chest
<b>ULTRASOUND</b>		<input type="checkbox"/>	Breast MRI	<input type="checkbox"/>	Extremity _____
<input type="checkbox"/>	Abdomen - Complete			<input type="checkbox"/>	Head
<input type="checkbox"/>	Aorta	<b>CT SCAN</b>		<input type="checkbox"/>	Hips
<input type="checkbox"/>	Breast: <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/>	<input type="checkbox"/> WITH IV CONTRAST <input type="checkbox"/> W/O IV CONTRAST	<input type="checkbox"/>	Lumbar Spine
<input type="checkbox"/>	Extremity _____	<input type="checkbox"/>	<input type="checkbox"/> W & W/O IV CONTRAST	<input type="checkbox"/>	Lumbar Spine to include Sacrum/Coccyx
<input type="checkbox"/>	Fine Needle Aspiration	<input type="checkbox"/>	Abdomen Only	<input type="checkbox"/>	MRCP
<input type="checkbox"/>	Gallbladder/Liver	<input type="checkbox"/>	Abdomen and Pelvis	<input type="checkbox"/>	Pelvis
<input type="checkbox"/>	Kidney/Bladder	<input type="checkbox"/>	Base of Skull w/Contrast	<input type="checkbox"/>	Soft Tissue Neck
<input type="checkbox"/>	OB	<input type="checkbox"/>	Cardiac Scoring	<input type="checkbox"/>	Thoracic Spine
<input type="checkbox"/>	OB/Transvaginal	<input type="checkbox"/>	Cervical Spine	<b>MR ANGIOGRAM</b>	
<input type="checkbox"/>	Nuchal Translucency	<input type="checkbox"/>	Chest	<input type="checkbox"/>	MR Angio - Abdomen/Pelvis w/Runoff
<input type="checkbox"/>	Pancreas	<input type="checkbox"/>	Extremity _____	<input type="checkbox"/>	MR Angio - Brain
<input type="checkbox"/>	Pelvic	<input type="checkbox"/>	Head	<input type="checkbox"/>	MR Angio - Carotid
<input type="checkbox"/>	Pelvic/Transvaginal	<input type="checkbox"/>	Lumbar Spine	<input type="checkbox"/>	MR Angio - Renal
<input type="checkbox"/>	Testicular	<input type="checkbox"/>	Lumbar Spine to include Sacrum/Coccyx	<b>NOTES</b>	
<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	Neck/Soft Tissue		
		<input type="checkbox"/>	Pelvis Only		

**ALL EXAMINATIONS IF YOU ARE DIABETIC OR ARE ALLERGIC TO IODINE, PLEASE CALL OUR OFFICE FOR INSTRUCTIONS.**

If you have previous x-rays, examination films, or reports, please bring them with you. Follow all instructions for your exam(s) very closely.

As a patient, you have the right to seek medical care at the facility of your choice. If you decide to seek continued care with MD Imaging, Inc., we have the capability to provide this care.



## TO PREPARE FOR YOUR EXAMINATION

### RADIOLOGY

#### **BONE DENSITY WITH IVA** (Allow 30 minutes)

Do not take calcium supplements or multivitamins for two (2) days prior to your exam.

#### **CYSTOGRAM or CYSTOURETHROGRAM**

(Allow 1 hour)

Patient needs to be catheterized prior to study by their physician.

#### **ESOPHAGRAM** (Allow 30 minutes)

**Nothing by mouth for four (4) hours prior** to study unless otherwise directed.

#### **G.I.SERIES** (Allow 30 minutes)

**Take nothing by mouth (food or liquid) after midnight** the evening before your exam.

**Note:** This exam may cause temporary constipation. Drink plenty of water and take a mild laxative, if necessary, after the exam.

#### **G.I.SERIES (WITH SMALL BOWEL) SMALL BOWEL ONLY** (Allow 2-4 hours)

**Take nothing by mouth (food or liquid) after midnight** the evening before your exam. Drink plenty of water and take a mild laxative, if necessary, after the exam.

#### **HYSTEOSALPINGOGRAM** (Allow 1 hour)

Schedule within ten (10) days of onset of menstrual cycle. No unprotected intercourse from onset of menstrual cycle until after your exam.

#### **LUMBAR PUNCTURE / MYELOGRAM**

(Allow 5-6 hours)

Patient should drink plenty of fluids prior to study. **No solid food after midnight the night** before study. Patient will need a driver for the ride home. If you live 30 or more miles from Redding, patient will need to make arrangements to spend the night in Redding. Please call our office for additional instructions.

### ULTRASOUND (SONOGRAM)

(Allow 45 minutes each)

• ABDOMEN (complete), AORTA, GALLBLADDER / LIVER or PANCREAS: **Nothing by mouth (food or liquid) six (6) hours prior to study.**

• KIDNEY/BLADDER: **Nothing by mouth (food or liquid) six (6) hours prior to study EXCEPT:** Drink 24 ounces of water 1-1/2 hours prior to study. All water intake must be finished one (1) hour prior to study. Patient must have a **full bladder** for the study to be successful.

• PELVIS, OB or NUCAL TRANSLUCENCY: Patient must drink one (1) quart of water 1-1/2 hours prior to study. All water intake must be finished one (1) hour prior to study. Patient must have a **full bladder** for the study to be successful.

#### **ABDOMEN DOPPLER** (Allow 1 hour)

**Nothing by mouth (food or liquid) six (6) hours** prior to study.

### BREAST IMAGING

**BREAST SONOCORE BIOPSY, BREAST / CYST ASPIRATION, BREAST FINE NEEDLE ASPIRATION, BREAST LOCALIZATION, BREAST - STEREOTACTIC BIOPSY**

Please wear your hair up with no necklace or earrings. Wear slacks and a firm/supportive bra. **Note:** No aspirin or arthritis medication 72 hours prior to your procedure. If you are currently taking a blood thinner, call MD Imaging three (3) days prior to your appointment.

#### **MAMMOGRAM** (Allow 30 minutes)

Please bring or have any prior mammograms sent to MD Imaging (Women's Imaging Center) for comparison.

#### **BREAST MRI** (Allow 1 hour)

**Nothing by mouth four (4) hours prior** to exam. Study to be performed **during or after** menstrual period (days 3 through 13)

#### **CT SCAN** (Allow 20-30 minutes)

If you are diabetic, being treated with medications or **allergic to iodine**, call our office for instructions.

• ABDOMEN / PELVIS WITH ORAL CONTRAST: Exam requires one (1) day preparation. Prep and instructions may be picked up at our radiology office.

• CARDIAC SCORING: No caffeine day of exam.

• HEAD, NECK or CHEST: **If your CT requires IV contrast, do not eat or drink anything for four (4) hours prior** to your scan. If you have poor kidney function, IV Contrast studies require current Creatinine and GFR lab results. Regular medication may be taken with a very small amount of water.

• UROGRAM: **Nothing by mouth four (4) hours prior** to exam. No oral contrast needed.

#### **CT ANGIOGRAM** (Allow 30 min)

NO ORAL CONTRAST

**Do not eat or drink anything four (4) hours prior** to your exam, including oral contrast.

• CORONARY: (Allow 45 minutes)

**Nothing by mouth four (4) hours prior** to exam. No caffeine day of exam.

#### **MRI / OPEN MRI** (Allow 1 hour)

Please do not wear jewelry, hairpins, eye makeup or any metal objects. Glasses, dentures, hearing aids and watches will be removed at the time of the examination; you will be provided a locker. **If your MRI requires contrast, do not eat or drink anything for four (4) hours prior** to your scan. **Regular medications may be taken with a very small amount of water.**

#### **MR ANGIOGRAM** (Allow 1 hour)

**Do not eat or drink anything four (4) hours prior** to your exam.

**PEDIATRIC PREPS** Sometimes children require sedation, usually under the age of 5. Please obtain instructions from MD Imaging or your physician.

## DIRECTIONS

**From Interstate 5 (north or south bound) or Highway 44**

- Take the Highway 44 West/Central Redding exit
- Stay on highway, which becomes Shasta Street
- Turn left at Court Street
- Turn right on Gold Street
- MD Imaging Center will be on the left

