DESERT ▪ MEDICAL ▪ IMAGING

John F. Feller MD Christopher R. Hancock MD Stuart T. May MD Adam J. Brochert MD

Scheduling Dept. Ph (760) 694-9559 • Fax (760) 356-8208

Today's Date_____ Next Office Visit_____

Patients Name:_____ Date of Birth:_____ Sex: M☐ F☐

Home Number:_____ Work Number:_____ Cell Number:_____

Clinical History/Diagnosis: _____

_____

Referring Physician:_____ Phone:_____ Fax:_____

Physician Signature: _____

MRI

☐ Without Contrast
☐ Without & With Contrast
☐ Abdomen
☐ MRCP
☐ Brain/Head
☐ w/ special attention to IAC
☐ w/ Neuroquant
☐ Breast Bilateral
☐ w/ implants
☐ Chest
☐ Extremity: Joint ☐R ☐L
Specify body part_____
☐ Extremity: Non-joint ☐R ☐L
Specify body part_____
☐ Hip ☐R ☐L
☐ Neck - Soft Tissue
☐ Orbits
☐ Pelvis ☐Bony ☐Soft Tissue
☐ Prostate (Contrast Required)
☐ Spine:
☐Cervical ☐Thoracic ☐Lumbar
☐ TMJ ☐R ☐L ☐Bilateral
☐ Other:_____

MR Angiography (MRA)

☐ Without Contrast
☐ With IV Contrast & 3D Recon
☐ Abdomen/Pelvis
☐ AIF Runoff
☐ Aorta ☐Renal Arteries
☐ Brain/Head
☐ Chest
☐Arch ☐Thoracic Aorta
☐ Neck/Carotids
☐ Upper Extremity ☐R ☐L
☐ Other:_____

Arthography

☐ MR ☐ CT
Including CT Guidance Injections
☐ Elbow ☐R ☐L
☐ Hip ☐R ☐L
☐ Knee ☐R ☐L
☐ Shoulder ☐R ☐L
☐ Wrist ☐R ☐L
☐ Other:_____

CT

☐ Without Contrast
☐ Without & With Contrast
☐ Abdomen
☐ Abdomen and Pelvis
☐ Bone Density (Lumbar)
☐ Brain/Head
☐ Chest
☐ Extremity ☐R ☐L
Specify body part_____
☐ IAC/Temporal Bone
☐ Lumbar Tap
must include lab instructions
☐ Maxillofacial - Facial Bones
☐ Neck (Soft Tissue);
☐Max. ☐Mand.
☐ Sinus
☐ Spine:
☐Cervical ☐Thoracic ☐Lumbar
☐ Orbits
☐ Pelvis
☐ Urogram (Abdomen/Pelvis)
☐ Other:_____

CT Angiography

With IV Contrast
☐ Abdomen/Pelvis
☐ AIF Runoff
☐ Brain/Head
☐ Coronary Arteries *(IW only)*
☐ Chest
☐ Extremity ☐Upper ☐Lower
☐ Neck/Carotids

If Diabetic, please include:
BUN:_____
Creatinine: _____
GFR:_____
Lab Date: _____
Is patient on Dialysis? _____

Ultrasound

☐ Abdomen
☐ Abdominal Hernia
☐ Aorta
☐ Arterial
Upper (Arm) ☐R ☐L
Lower (Leg) ☐R ☐L
☐ Breast ☐R ☐L
☐ Carotid (CIMT)
☐ Extremity ☐R ☐L
Specify body part_____
☐ Gallbladder
☐ Liver
☐ Nuchal Translucency
☐ OB/Fetal LMP_____
☐ w/ Endovaginal
☐ Pelvic
☐ w/ Endovaginal
☐ Renal
☐ Scrotal (Testicular)
☐ Thyroid
☐ Urinary Bladder
☐ Venous Doppler
Upper (Arm) ☐R ☐L
Lower (Leg) ☐R ☐L
☐ Other:_____

Therapeutic Injections

☐ Foot ☐R ☐L
☐ Hip ☐R ☐L
☐ Knee ☐R ☐L
☐ Shoulder ☐R ☐L
☐ Spine (Facets)
☐Cervical ☐Thoracic ☐Lumbar
☐ Wrist ☐R ☐L
☐ Other:_____

Biopsies

☐ Liver
☐ Prostate (MRI Only)
☐ Renal
☐ Soft Tissue Mass
☐ Thyroid
☐ Other:_____

PET/CT

☐ Brain Amyvid
☐ FDG-18 Brain Metabolic
☐ FDG-18 Skull Base to Mid Thigh
☐ FDG-18 Whole Body - Vertex Skull to Toes
☐ NaF-18 Whole Body Bone Scan
☐ Other:_____

Screening Procedure

Not covered by Insurance
☐ CT Coronary Angiography*
☐ CT Coronary Calcium Score*
☐ CT Lung Screening*
☐ CT Virtual Colonography*
☐ CT Whole Body Scan
☐ MRI Whole Body Scan

**May be covered by insurance with specific diagnosis*

Please fax a copy of the patient's insurance card(s), and any pertinent clinical information, with this order. If additional information is needed, we will contact your office.

If an exam requires authorization, the authorization must be obtained before the patient is scheduled.

Insurance Company_____

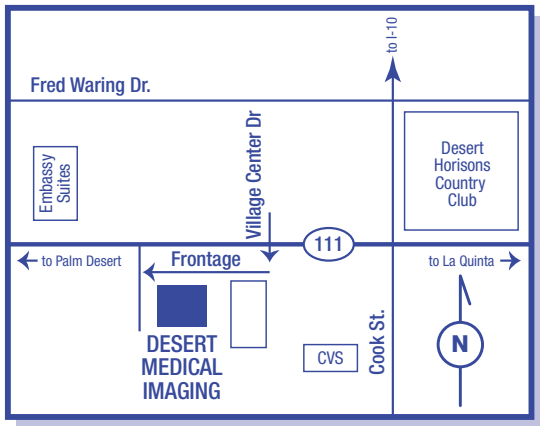
INSURANCE AUTHORIZATION # _____

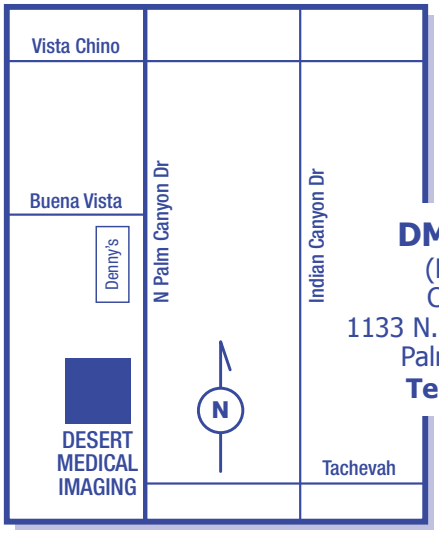
Additional Comments/Instructions:_____

Scheduling Dept. Ph (760) 694-9559 • Fax (760) 356-8208

DMI Indian Wells

(Hi-Field MRI, 64 Slice CT, Ultrasound and PET/CT)
74-785 Highway 111, Suite 101
Wall Street West Building Indian Wells, CA 92210
DMI Tel: (760) 776-8989 PET/CT Tel: (760) 346-4329



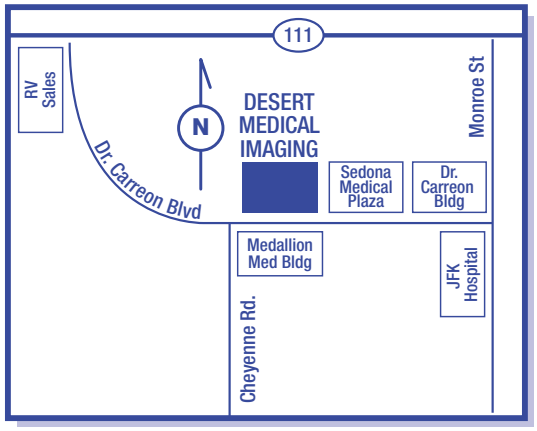


DMI Palm Springs

(Hi-Field Open MRI,
CT and Ultrasound)
1133 N. Palm Canyon Dr., Suite B
Palm Springs, CA 92262
Tel: (760) 322-8883

DMI Indio

(Hi-Field Open MRI, CT and Ultrasound)
81-800 Dr. Carreon Boulevard, Suite C
Indio, CA 92201
Tel: (760) 863-4085



Locations and Preparation Instructions

Please call us if you have any questions regarding your procedure or preparation for you procedure. Study times vary in length. Bring your insurance card and a picture I.D. with you on the day of your exam.

- ☐ **MRI Scan:** Please inform us if you have a pacemaker or any metal in your body at time of scheduling. Remove any metal, jewelry or hair pins prior to your scan. Specific preparation information will be given when your appointment is scheduled.
- ☐ **CT Scan:** Some CT's require contrast, please inform us if you are allergic to iodine.
- ☐ **Ultrasound (Abdomen, Gallbladder, Aorta):** No food or drink 6 hours prior to your exam.
- ☐ **Ultrasound (Pelvic or Bladder):** To fill your bladder, please drink 32 ounces of fluids to be completed one hour before your exam. Do not empty your bladder before your exam.
- ☐ **Ultrasound (OB):** To fill your bladder, please drink 32 ounces of fluid to be completed one hour before your exam. Do not empty your bladder before your exam

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After the Exam: Your exam will be read by a board-certified, licensed Radiologist with specialty training. The results of your exam will be sent to your physician. You will receive your results from your physician.

Billing Information: *If you have insurance coverage, we will submit a claim to your insurance company on your behalf. If your exam requires authorization, we will obtain the authorization before we schedule your exam. Deductibles and co-insurance will be collected at time of service. If you have any billing questions please call our Billing Department at 760-836-3835.*

- *For your safety, children may not accompany patients into procedures. If it is necessary to bring children to the appointment, please bring appropriate adult supervision to watch your children during the scan.*
- *If scheduled for a CT or MRI exam, please inform us if you may be pregnant.*
- *If you have asthma, please bring your inhaler to the appointment.*

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