Touchstone
MEDICAL IMAGING

Please Select Facility - See back for specific location information

ACCREDITED FACILITY · IAC · INTERSOCIETAL ACCREDITATION COMMISSION

Appt. Date _____

Appt. Time _____

❑ **SOUTH AUSTIN**
4316 James Casey Street, Suite E-1
Austin, TX 78745-1157
Phone: 512.454.9597
Fax: 512.459.7449

❑ **CENTRAL AUSTIN**
711 W. 38th Street, Suite B-7
Austin, TX 78705-1121
Phone: 512.454.9597
Fax: 512.459.7449

❑ **NORTH AUSTIN**
11575 Jollyville Road
Austin, TX 78759-4028
Phone: 512.454.9597
Fax: 512.459.7449

❑ **ROUND ROCK**
15808 RR 620 North, Suite 110
Austin, TX 78717-4923
Phone: 512.454.9597
Fax: 512.459.7449

❑ **WACO**
312 Richland West Circle
Waco, TX 76712-7919
Phone: 254.755.4410
Fax: 254.755.4413

❑ **NORTH WACO**
922 S. 10th St., Suite 220
Waco, TX 76706-1388
Phone: 254.307.0252
Fax: 254.307.0257

Patient Name: _____ DOB: _____

Cell Phone: _____ Insurance ID#: _____

Home/Work Phone: _____ Authorization: _____

REFERRING PHYSICIAN SIGNATURE:

X _____ _____ **Ordered Date**

DIAGNOSIS: _____

PHYSICIAN NOTES:

_____

_____

_____

❑ **STAT CALL** _____ **Cell Phone #**

❑ **STAT Fax#** _____

❑ Deliver CD to Office

❑ Send CD w/Patient

❑ Please Compare to Previous _____

Print Referring Dr.: _____ Referring Office Contact: _____

Office Phone: _____ Office Fax: _____

■ MRI

❑ **1.5T Wide-Bore MRI** ❑ **3T MRI**
❑ **1.2T Open MRI (Waco)**
❑ **Without Contrast** ❑ **With & Without Contrast**
❑ **MRAngiogram**
❑ **Arthrogram (with intra-articular contrast)**
❑ **MRI Elastography**

*Labs needed for IV contrast IF:
❑ **Age 60 & up** ❑ **Diabetic** ❑ **Renal DX**
Creatinine: _____

❑ Brain
Volumetric Analysis Report:
❑ Dementia/ALZ ❑ ARIA
❑ Epilepsy ❑ MS ❑ TBI
❑ Orbits
❑ Orbits & Brain
❑ Pituitary
❑ Internal Auditory Canals
❑ Cervical
❑ Thoracic

❑ Lumbar
❑ Sacrum
❑ Soft Tissue Neck
❑ TMJ
❑ Abdomen
❑ LiverMultiScan®
❑ Chest (HF Only)
❑ MRCP (HF Only)
❑ Renal (HF Only)
❑ Pelvis

❑ Shoulder ❑ R ❑ L
❑ Hip ❑ R ❑ L
❑ Hand ❑ R ❑ L
❑ Wrist ❑ R ❑ L
❑ Elbow ❑ R ❑ L
❑ Knee ❑ R ❑ L
❑ Ankle ❑ R ❑ L
❑ Foot ❑ R ❑ L
❑ Extremity _____
❑ Prostate with Mapping (Requires 3T)
❑ Other _____

■ CT

❑ **CT**
❑ **With Contrast**
❑ **Without Contrast** ❑ **With & Without Contrast**
❑ **Calcium Scoring**
❑ **Arthrogram (with intra-articular contrast)**

*Labs needed for IV contrast IF:
❑ **Age 60 & up** ❑ **Diabetic** ❑ **Renal DX**
Creatinine: _____

❑ Brain
❑ Orbits
❑ Sinuses - Axial
❑ Mandible/Facial Bones
❑ Temporal Bones
❑ Soft Tissue Neck
❑ Chest
❑ Cervical
❑ Lumbar
❑ Thoracic

❑ Abdomen
❑ Pelvis
❑ Abdomen/Pelvis
❑ Kidney Stone Protocol
Abd/Pel wo
❑ Enterography
❑ Scaphoid ❑ R ❑ L
❑ Hip ❑ R ❑ L
❑ Extremity _____
_____

❑ CTA (w/ 3D Reformat)
❑ Abdomen/Pelvis
❑ Neck
❑ Renal
❑ Chest (P.E. Protocol)
❑ Other _____

■ ULTRASOUND

❑ Abdominal Complete (NPO)
❑ Abdominal Doppler Complete
❑ Abdominal Limited (NPO)
❑ Aorta
❑ Arterial Doppler Lower Extremity ❑ R ❑ L ❑ Bilat
❑ Arterial Doppler Upper Extremity ❑ R ❑ L ❑ Bilat
❑ Carotid Artery Doppler

❑ Gallbladder/Liver/Pancreas
❑ OB Bio Physical Profile
❑ OB > 14 Weeks
❑ OB < 14 Weeks
❑ Pelvic (w/ Transvaginal, if needed)
❑ Pelvic Only
❑ Renal Artery Doppler

❑ Renal Complete
❑ Soft Tissue:
_____
❑ Testicular/Scrotal
❑ Thyroid
❑ Transvaginal Only

❑ Venous Doppler Upper Extremity
❑ R ❑ L ❑ Bilat
❑ Venous Doppler Lower Extremity
❑ R ❑ L ❑ Bilat
❑ Other _____

■ ADDITIONAL SERVICES

❑ **X-RAY**
Exam Requested: _____
Reason for Exam: _____

❑ **MYELOGRAM** ❑ Cervical _____ ❑ Thoracic _____ ❑ Lumbar _____

❑ **FLUOROSCOPY**
Exam Requested: _____
Reason for Exam: _____

❑ **BONE DENSITY**

PLEASE FAX SIGNED ORDERS, PATIENT DEMOGRAPHICS, INSURANCE & CLINICALS

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SERVICES: MRI [1.5T Wide-Bore] • CT • US
X-Ray/Fluoro • Bone Density • Arthrogram
Myelogram • Cardiac Scoring

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X-Ray/Fluoro • Bone Density • Arthrogram
Myelogram

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X-Ray/Fluoro • Arthrogram • Myelogram

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X-Ray

If you have had previous diagnostic studies of the body part being evaluated, please bring the CD and reports, or request they be sent to the Center. These studies or reports are very helpful to the Radiologist interpreting your exam.

COMPUTED TOMOGRAPHY (CT)
Abdomen or Abdomen and Pelvis
Please contact center for prep instructions.
Tell the CT Technologist:
- If you are pregnant or breast feeding
- If you have had a barium enema or UGI within the last two weeks
- If you have had brain, heart, ear, eye or other surgeries
- If you have had an IVP within 48 hours

MAGNETIC RESONANCE IMAGING (MRI)
Please let your MRI Technologist know if you have a pacemaker, surgical clips, a prosthesis, previous surgery, metal implants or any other metal objects in your body or if you are pregnant or nursing.

ULTRASOUND
Abdominal Ultrasound:
Please do not eat or drink (NPO) 6-8 hours prior to the exam.
Pelvic/OB <30 weeks:
Please have finished drinking four 8-ounce glasses of water 1 hour prior to your appointment time.
Your bladder must be full upon arrival. Pediatric patients drink 12 ounces of water 1 hour prior to appointment time.

FLUORO/BE Please contact center for prep.

X-RAY No Prep.