



*PATIENT NAME _____ *DOB (MM/DD/YYYY) _____ *PHONE _____
 INSURANCE CARRIER / ID _____ APPT. DATE / TIME _____ CALL PATIENT TO SCHEDULE
 SYMPTOMS _____
 STAT CALL RESULTS CELL PHONE REQUIRED IF "STAT" OR "CALL" BOX IS SELECTED

PROVIDER NPI # _____ *PHYSICIAN NAME - PRINTED _____ *SIGNATURE _____
 SPECIAL REQUEST _____ *ORDERED BY NAME - PRINTED _____ *SIGNATURE _____

| | | | |
|---|---|--|---|
| MRI <input type="checkbox"/> w/o IV contrast <input type="checkbox"/> w & w/o IV contrast | <input type="checkbox"/> Brain: <input type="checkbox"/> MS Protocol <input type="checkbox"/> Seizure <input type="checkbox"/> IAC / Orbits <input type="checkbox"/> Pituitary <input type="checkbox"/> Spine: <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Sacrum <input type="checkbox"/> Abdomen: <input type="checkbox"/> MRCP <input type="checkbox"/> Enterography CoMo Pref. <input type="checkbox"/> Other _____ <input type="checkbox"/> Pelvis: <input type="checkbox"/> Bony <input type="checkbox"/> Soft Tissue (reproductive) <input type="checkbox"/> Extremity (L/R): _____ <input type="checkbox"/> Other: _____ | SELF PAY SCREENING <input type="checkbox"/> Cardiac Calcium Scoring CT (\$105) <input type="checkbox"/> Carotid IMT US (\$105) <input type="checkbox"/> AAA Screening US (\$105) <input type="checkbox"/> Low Dose Lung Screening CT (\$215) <input type="checkbox"/> Body Composition (\$50) <input type="checkbox"/> DEXA (\$75) | |
| | <input type="checkbox"/> Head <input type="checkbox"/> Neck | GENERAL US <input type="checkbox"/> No Doppler* <input type="checkbox"/> Abdomen: <input type="checkbox"/> Cmpl. <input type="checkbox"/> Ltd. <input type="checkbox"/> Elastography <input type="checkbox"/> Thyroid <input type="checkbox"/> Kidney Cmpl. <input type="checkbox"/> Pelvic Only Hernia <input type="checkbox"/> Bladder Pre / Post Void <input type="checkbox"/> Scrotal <input type="checkbox"/> Extremity Non-vascular _____ | OB/GYN US <input type="checkbox"/> No Doppler* <input type="checkbox"/> Pelvic: <input type="checkbox"/> w/ TVS [Transvaginal] <input type="checkbox"/> TVS Only <input type="checkbox"/> TVS pregnant <input type="checkbox"/> OB 1 st Trimester (< 14 wks) <input type="checkbox"/> OB 2 nd & 3 rd Trimesters (> 14 wks) |
| | CT <input type="checkbox"/> w/ IV contrast <input type="checkbox"/> w/o IV contrast <input type="checkbox"/> w & w/o IV contrast <input type="checkbox"/> Oral contrast <i>BUN & creatinine completed on site.</i> | <input type="checkbox"/> Head: <input type="checkbox"/> Orbits <input type="checkbox"/> Sinus / Facial Bones <input type="checkbox"/> Sella / Ear / Temporal Bones <input type="checkbox"/> Spine: <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Neck Soft Tissue <input type="checkbox"/> Chest: <input type="checkbox"/> Low Dose Lung Screening PE protocol. Please see CTA <input type="checkbox"/> Abdomen <input type="checkbox"/> Abdomen Only <input type="checkbox"/> Urogram & Pelvis: <input type="checkbox"/> Pelvis Only <input type="checkbox"/> Enterography <input type="checkbox"/> Stone Protocol <input type="checkbox"/> Extremity: _____ | VASCULAR US <i>No TCD (Cranial)</i> <input type="checkbox"/> Aorta <input type="checkbox"/> Carotid <input type="checkbox"/> Renal Artery Doppler <input type="checkbox"/> Liver Doppler Cmpl. <input type="checkbox"/> Arterial Duplex: Extremity _____ <input type="checkbox"/> Venous Doppler: Extremity _____ <input type="checkbox"/> ABI - <input type="checkbox"/> Toe Pressures CoMo Only |
| CTA | <input type="checkbox"/> Head-Circle of Willis <input type="checkbox"/> Neck - Carotid Arteries <input type="checkbox"/> Chest / Abdomen Aorta <input type="checkbox"/> Chest PE Protocol <input type="checkbox"/> Abdomen - Renal Arteries <input type="checkbox"/> Abdomen / Pelvis <input type="checkbox"/> Aorta w/ Femoral Runoff | X-RAY <i>We will perform routine views if the number of views is not indicated</i> <input type="checkbox"/> Abdomen: (Views #) _____ <input type="checkbox"/> Chest: <input type="checkbox"/> 1 View PA <input type="checkbox"/> 2 View <input type="checkbox"/> Spine: <input type="checkbox"/> AP / Lateral <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Flex. / Ex. <input type="checkbox"/> Lumbar <input type="checkbox"/> Sacrum / Coccyx <input type="checkbox"/> Obliques <input type="checkbox"/> Scoliosis <input type="checkbox"/> Ribs (L/R): <input type="checkbox"/> w/ CXR (1 view) <input type="checkbox"/> Hip (L/R): <input type="checkbox"/> Bilateral <input type="checkbox"/> w/ Pelvis <input type="checkbox"/> Pelvis: <input type="checkbox"/> AP <input type="checkbox"/> Inlet/Outlet <input type="checkbox"/> Judet <input type="checkbox"/> Extremity: _____ Series: <input type="checkbox"/> Skull <input type="checkbox"/> Sinus <input type="checkbox"/> Other _____ | |
| DEXA | <input type="checkbox"/> DEXA - <input type="checkbox"/> w/ VFA CoMo & JC Only | | |

INTERVENTIONAL - COMO ONLY

| | |
|---|---|
| MR ARTHROGRAM <input type="checkbox"/> Shoulder (L/R) <input type="checkbox"/> Elbow (L/R) <input type="checkbox"/> Wrist (L/R) <input type="checkbox"/> Hip (L/R) <input type="checkbox"/> Knee (L/R) <input type="checkbox"/> Ankle (L/R) | MYELOGRAM <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar |
| | ULTRASOUND <input type="checkbox"/> Baker's Cyst Aspiration <input type="checkbox"/> Thyroid FNA |
| PAIN INTERVENTION: Level _____ | Joint Injection (L/R): Shoulder: <input type="checkbox"/> Glenohumeral <input type="checkbox"/> Subacromial <input type="checkbox"/> AC Joint Hip: <input type="checkbox"/> Intra-articular <input type="checkbox"/> Bursa <input type="checkbox"/> Knee <input type="checkbox"/> Finger <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> ESI / <input type="checkbox"/> Facet (L/R) / <input type="checkbox"/> Neuroforaminal (L/R): <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Blood Patch <input type="checkbox"/> Trigger Point Injection <input type="checkbox"/> Sacroiliac (L/R): <input type="checkbox"/> Marcaine Only <input type="checkbox"/> Other: _____ |

! PLEASE NOTE !

- CT & MRI: CoMo - Closed High Field ≥ 350 lbs. / CT ≥ 450 lbs., JC & OB - Open Low Field ≥ 450 lbs. / CT ≥ 500 lbs.
- US [Ultrasound]: All General, OB/GYN & Vascular orders include Doppler. *Must opt-out to not receive. No infant heads, hips, or spines. No MSK US at all locations.
- No prostate or breast imaging. Pacemakers / stimulators not accepted at JC & OB locations. Other services, if not listed, may not be offered.
- ESI is done with interlaminar approach only.
- Contrast is at discretion of radiologist.

PORTAL



<https://aradiology.com/physician-resources/>

| | | |
|---|---|--|
| COLUMBIA ☎ (573) 442-1788 ☎ (573) 442-1789 | JEFFERSON CITY ☎ (573) 635-6262 ☎ (573) 635-9786 | OSAGE BEACH ☎ (573) 746-7010 ☎ (573) 746-7011 |
|---|---|--|

! PATIENTS TAKING MEDICATIONS - PLEASE CHECK WITH YOUR REFERRING PHYSICIAN !

COLUMBIA

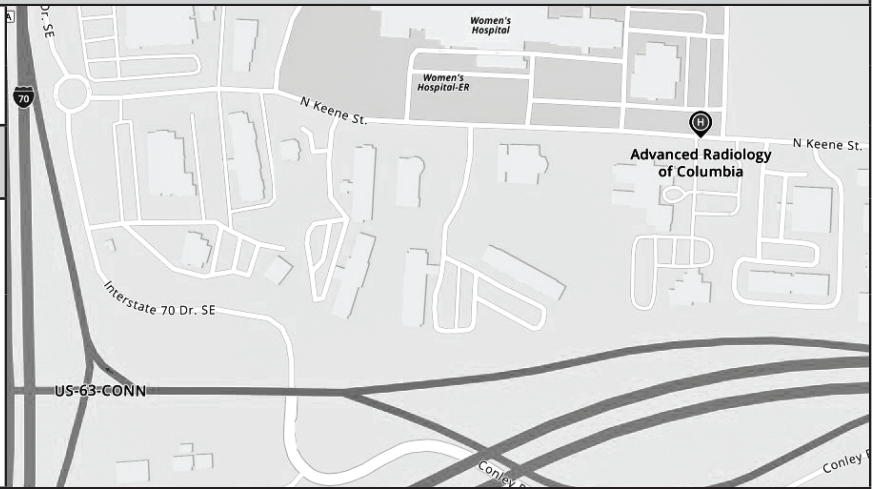
311 N KEENE ST., COLUMBIA, MO 65201

(573) 442-1788 NPI: 1861587149
(573) 442-1789 Tax ID: 826546353

APPOINTMENT

DATE _____ TIME _____

Located across from MU Women's & Children's Hospital, behind Boone Clinic. **Look for the big purple ADVANCED RADIOLOGY sign.**



JEFFERSON CITY

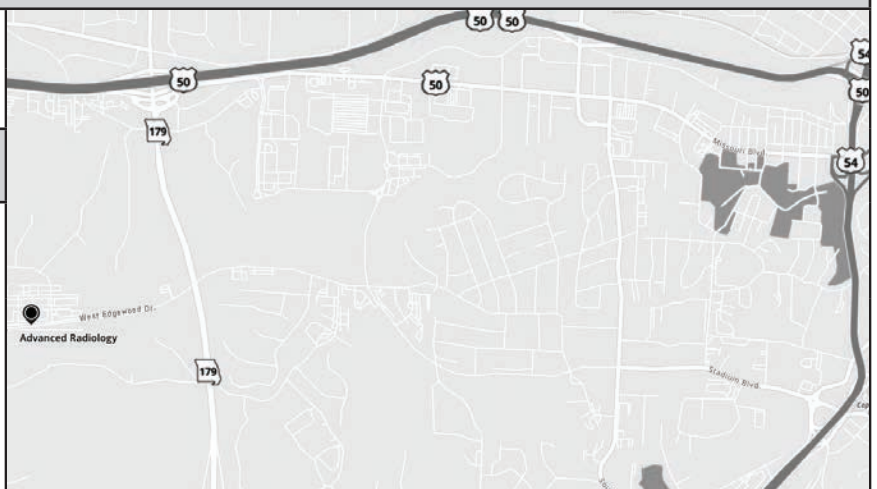
3218 WEST EDGEWOOD BLVD., STE. 200, JEFFERSON CITY, MO 65109

(573) 635-6262 NPI: 1568621175
(573) 635-9786 Tax ID: 1568621175

APPOINTMENT

DATE _____ TIME _____

Located in the **West Edgewood Centre Plaza** with Dunn Brothers Coffee.



OSAGE BEACH

1037 PALISADES BLVD., STE. 7 & 8, OSAGE BEACH, MO 65065

(573) 746-7010 NPI: 1093870982
(573) 746-7011 Tax ID: 208085012

APPOINTMENT

DATE _____ TIME _____

Exit at KK. Coming from I-54 Westbound? Take a left at the light. Eastbound? Turn right. Take a right at the next light by **Central Bank**, then another right onto Palisades before McDonald's. You'll find us at the end of the road in the last building on the right next to **Lake Family Dentistry**.



! PATIENTS TAKING MEDICATIONS - PLEASE CHECK WITH YOUR REFERRING PHYSICIAN !