Radiology Associates LLP

361-887-7000 (option 2)
Toll Free 1-877-626-8678 | Central Fax: 361-561-3107

REPORT URGENCY

❑ Regular Fax ❑ STAT Fax

❑ STAT Call Report *(Please include cell # below for STAT or Abnormal findings):

Cell #: _____

*Indicates required fields

Date: _____

INCLUDE AUTHORIZATION NUMBER (WHEN/IF NEEDED): _____

Patient: _____ DOB: _____

Appointment Date/Time: _____ Arrival Time: _____

Patient Phone Number: _____ Alternate Phone Number: _____

****

Please note: IV Contrast will be used at the discretion of the radiologist unless otherwise indicated below.

Exam #1

❑ MRI ❑ MRA ❑ CT ❑ CTA ❑ X-ray ❑ Fluoroscopy ❑ Ultrasound ❑ Doppler ❑ Nuclear Medicine ❑ PET/CT

Body Part: _____ Lt / Rt / Bil ICD10: _____

Exam reason: _____

_____

Exam #2

❑ MRI ❑ MRA ❑ CT ❑ CTA ❑ X-ray ❑ Fluoroscopy ❑ Ultrasound ❑ Doppler ❑ Nuclear Medicine ❑ PET/CT

Body Part: _____ Lt / Rt / Bil ICD10: _____

Exam reason: _____

_____

Exam #3

❑ MRI ❑ MRA ❑ CT ❑ CTA ❑ X-ray ❑ Fluoroscopy ❑ Ultrasound ❑ Doppler ❑ Nuclear Medicine ❑ PET/CT

Body Part: _____ Lt / Rt / Bil ICD10: _____

Exam reason: _____

_____

Mammo/Dexa/Biopsy

❑ Screening Mammogram ❑ Bone Density (DXA) ❑ Breast Biopsy ❑ Thyroid Biopsy

❑ Diagnostic Breast Evaluation with Imaging as Needed (Diagnostic Mammogram and/or Breast US as indicated by patient/age/findings).

Exam reason: _____

_____

If more than one (1) location, please include practice address: _____

*Office Phone Number: _____ Office Fax Number: _____

*Referring Physician Name (Please Print): _____

*Referring Physician Signature: _____

CC to Other Physician: _____

All patients should confirm their appointments 24 hours in advance by calling 887-7000 (option 5)

Patient must present Photo ID & Insurance card at time of service.

Payment is due at time of service. Any necessary payment arrangements must be made prior to the appointment.

SEE REVERSE SIDE OF THIS FORM FOR INSTRUCTION ON PREPARING FOR YOUR EXAM

TAX I.D. #74-1087689 NPI 1558311340