Today's Date:
_____ /_____ /_____

ZOOM DIAGNOSTIC IMAGING

For Appointments: 580-540-3244
Fax Orders: 580-308-1023

Patient Name: _____

DOB: ___/___/_____ Employer: _____ SS#: _____

Insurance: _____ Group#: _____ Policy #: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Appointment Date: ___/___/_____ Time: _____ Pregnant: ☐ Yes ☐ No

Diagnosis Code: _____ Reason for Exam: _____

Referring Physician (Print): _____ Office Phone: _____

Office Contact: _____ Office Fax: _____

☐ STAT REPORT _____ ☐ CALL STAT _____ ☐ Deliver CD ☐ Send CD with Patient

MRI

☐ With Contrast ☐ Without Contrast
☐ With & Without Contrast ☐ RAD to Determine

NEURO/ENT/SPINE
☐ Brain
☐ Orbits
☐ Pituitary
☐ IAC
☐ Spine (select below)
☐ C ☐ T ☐ L
☐ TMJ
☐ Soft Tissue neck/parotid
Other _____

BODY & CHEST
☐ Abdomen
☐ Pelvis
☐ Prostate
☐ MRCP
☐ Breast MRI
☐ Clavicle/SC joint
☐ Scapula
☐ Sternum
Other _____

ORTHOPEDIC
☐ Extremity (select below)
☐ Left Arm ☐ Right Arm
☐ Left Leg ☐ Right Leg
Specify _____
☐ Wrist ☐ R ☐ L
☐ Knee ☐ R ☐ L
☐ Hip ☐ R ☐ L
☐ Shoulder ☐ R ☐ L

MRA
☐ Intracranial/ Circle of Willis
☐ Carotid

CT

☐ With Contrast ☐ Without Contrast
☐ With & Without Contrast ☐ RAD to Determine

☐ Lung Screening
☐ Brain
☐ Spine (select below)
☐ C ☐ T ☐ L
☐ Facial bones
☐ Temporal lobes
☐ Complete Sinuses
☐ Soft Tissue Neck
☐ Extremity (select below)
☐ Left Arm ☐ Right Arm
☐ Left Leg ☐ Right Leg

☐ Chest
☐ Abdomen Only
☐ Pelvis Only
☐ Abdomen & Pelvis Combined
☐ CTA _____
☐ Other _____

ULTRASOUND

☐ Carotids
☐ Extremity
☐ Pelvic
☐ Renal Doppler
☐ Abdominal
☐ Breast
☐ Renal Ultrasound
☐ AAA
☐ Echocardiogram

☐ Venous ☐ Leg ☐ R ☐ L ☐ Bilat
☐ Arm ☐ R ☐ L ☐ Bilat
☐ Arterial ☐ Leg ☐ R ☐ L ☐ Bilat
☐ Arm ☐ R ☐ L ☐ Bilat
☐ Other _____

X-RAY

☐ Chest PA & LAT
☐ Abdomen, KUB
☐ Abdominal Series
☐ Pelvis
☐ C-Spine
☐ T-Spine
☐ L-Spine
☐ Other _____

☐ Shoulder ☐ R ☐ L
☐ Elbow ☐ R ☐ L
☐ Wrist ☐ R ☐ L
☐ Hand ☐ R ☐ L
☐ Hip ☐ R ☐ L
☐ Knee ☐ R ☐ L
☐ Ankle ☐ R ☐ L
☐ Foot ☐ R ☐ L

I certify that the item(s) prescribed is medically necessary for the treatment of this patient for the above condition and this information is documented in the patient medical records:

Referring Physician Signature: _____ Date: ___/___/_____

(No Stamped Signatures)