TODAY'S DATE
___ /___ /___

ZOOM
DIAGNOSTIC IMAGING

1228 Merrick Dr
Ardmore, OK 73401
office 580-319-5091
fax 580-205-5012

Patient Name: _____ DOB: ___ /___ /___
Employer: _____ SSN: ___ /___ /___
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

☐ Shoulder ☐ R ☐ L
☐ Upper arm ☐ R ☐ L
☐ Elbow ☐ R ☐ L
☐ Forearm ☐ R ☐ L
☐ Wrist ☐ R ☐ L
☐ Hand ☐ R ☐ L
☐ Finger ☐ R ☐ L
Specify _____
☐ Pelvis ☐ R ☐ L
☐ Hip ☐ R ☐ L
☐ Thigh ☐ R ☐ L
☐ Knee ☐ R ☐ L
☐ Lower Leg ☐ R ☐ L
☐ Ankle ☐ R ☐ L
☐ Foot ☐ R ☐ L
☐ Toe ☐ R ☐ L
Specify _____

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 Bones
☐ Complete Sinuses
☐ Soft Tissue Neck
☐ Extremity (select below)
☐ Left Arm ☐ Right Arm
☐ Left Leg ☐ Right Leg
☐ Chest
☐ Abdomen Only
☐ Pelivs Only
☐ Abdomen & Pelvis Combined
☐ CTA _____
☐ Other _____

X-RAY

Chest PA & LAT ☐
Abdomen, KUB ☐
Abdominal Series ☐
Pelvis ☐
C-Spine ☐
T-Spine ☐
Scapula ☐
Orbits ☐
Sinus ☐

L-Spine ☐
Shoulder ☐ R L
Elbow ☐ R L
Hand ☐ R L
Hip ☐ R L
Wrist ☐ R L
Skull ☐
Facial Bones ☐

Knee ☐ R L
Ankle ☐ R L
Foot ☐ R L
Forearm ☐
Humerus ☐
Tibia/Fibula ☐
Femur ☐

ULTRASOUND

☐ Carotids
☐ Extremity
☐ Pelvic
☐ Renal Doppler
☐ Abdominal
☐ Breast
☐ Renal US
☐ AAA
☐ Other
☐ Echocardiogram

Venous ☐
Leg ☐ R L
Arm ☐ R L
Bilat ☐

Arterial ☐
Leg ☐ R L
Arm ☐ R L
Bilat ☐

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)