alinea
MEDICAL IMAGING

a Rezolut partner

PHYSICIAN REFERRAL FORM

REF DR: PHONE #:

REF DR SIGNATURE:

☐ STAT REPORT ☐ FAX: ________________
☐ IMAGES ON CD ☐ ONLINE ACCESS REQUESTED

PRECERT/REF #'S:

PATIENT NAME: TODAY'S DATE:

DOB: CONTACT #:

INDICATION/DIAGNOSIS:

ALLERGIES: ☐ NONE ☐ IV CONTRAST ☐ LATEX ☐ OTHER:

ULTRASOUND

GENERAL

☐ ABDOMEN ☐ LTD (RUQ) ☐ COMP
☐ PELVIS ☐ TRS ABD ☐ ENDO
☐ BREAST ULTRASOUND ☐ R ☐ L ☐ B
☐ THYROID
☐ SCROTUM/TESTICULAR
☐ BLADDER
☐ RENAL
☐ LOWER EXTREMITY ☐ ARTERIAL ☐ VENOUS
OTHER: ________________

OBSTETRIC

☐ OB COMPLETE ☐ >14 wks ☐ <14 wks
☐ OB LIMITED
☐ OB FOLLOW-UP/REPEAT
☐ FETAL SEX ONLY
☐ OB NUCHAL TRANSLUCENCY
OTHER: ________________

VASCULAR

☐ ABDOMINAL AORTA
☐ CAROTID
☐ UPPER VENOUS DOPPLER ☐ R ☐ L
☐ LOWER VENOUS DOPPLER ☐ R ☐ L
OTHER: ________________

X-RAY (In Pomona Only Walk-in M-F: 8:30am - 4:30pm)

HEAD

☐ SKULL ☐ ORBITS ☐ FACIAL BONES
☐ SINUS ☐ MANDIBLE ☐ NASAL BONES

BODY

☐ CHEST ☐ 1 VIEW ☐ 2 VIEWS
☐ RIBS ☐ R ☐ L ☐ B
☐ STERNUM
☐ ABDOMEN ☐ FLAT ☐ ERECT ☐ DECUB
☐ PELVIC AP

SPINE ☐ STANDING ☐ FLEX/EXT

☐ C-SPINE ☐ 3 VIEWS ☐ 5 VIEWS
☐ T-SPINE
☐ L-SPINE ☐ 3 VIEWS ☐ 5 VIEWS
☐ SCOLIOSIS SERIES
☐ AC JOINTS
☐ SACRUM/COCCYX
☐ SI JOINTS (3 view)
OTHER ________________

UPPER EXTREMITIES

☐ CLAVICLE ☐ R ☐ L ☐ B
☐ SCAPULA ☐ R ☐ L ☐ B
☐ SHOULDER ☐ R ☐ L ☐ B
☐ HUMERUS ☐ R ☐ L ☐ B
☐ ELBOW ☐ R ☐ L ☐ B
☐ FOREARM ☐ R ☐ L ☐ B
☐ WRIST ☐ R ☐ L ☐ B
☐ HAND ☐ R ☐ L ☐ B
☐ FINGER ☐ R ☐ L ☐

LOWER EXTREMITIES

☐ HIP ☐ R ☐ L ☐ B
☐ FEMUR ☐ R ☐ L ☐ B
☐ KNEE ☐ R ☐ L ☐ B
☐ TIB-FIB ☐ R ☐ L ☐ B
☐ ANKLE ☐ R ☐ L ☐ B
☐ FOOT ☐ R ☐ L ☐ B
☐ HEEL ☐ R ☐ L ☐ B

WEIGHTBEARING ☐ Y ☐ N

MISC

☐ **EKG** (Study only)
☐ **BONE DENSITY** (Heel Scan)

BREAST IMAGING

☐ SCREENING MAMMOGRAM
☐ DIAGNOSTIC MAMMOGRAM ☐ R ☐ L ☐ B
☐ BREAST ULTRASOUND ☐ R ☐ L ☐ B
☐ BREAST MRI ☐ R ☐ L ☐ B

General Instructions / Instrucciones Generales

- **Please bring your insurance card.** *Por favor traiga su informacion de su seguro.*
- **Please bring this requisition and any health plan authorization with you to your appointment. We cannot perform any exam without a doctor's order or authorization.** *Por favor traiga esta solicitud y la autorización del plan de salud con usted a su cita. No se puede realizar ningún examen sin la orden de un médico o autorización.*
- **If you cannot keep your appointment, please call us at (909) 622-3166 to reschedule.** *Si no puede asistir a su cita, por favor llamenos al (909) 622-3166 para reprogramar su cita.*
- **Please arrive 20 minutes prior to your exam to register.** *Por favor llegue 20 minutos antes del examen para inscribirse.*

ULTRASOUND / ULTRASONIDO

- **ABDOMEN - Do not eat or drink anything for the 6 hours prior to your exam.** *No comer ni beber nada durante las 6 horas antes del examen.*
- **PELVIC / OB / RENAL - Drink 4-6 glasses of water 1 hour before your exam. Do not empty your bladder.** *Beber 4 a 6 vasos de agua, una hora antes de su ultrasonido. No vacíe su vejiga.*

X-RAY / RADIOGRAFÍA

- **There are no preparations required for an x-ray exam.** *No hay intrucciones especiales para un examen de rayos x.*
- **Women who may be pregnant should always inform their doctor or technologist.** *Las mujeres que puedan estar embarazadas siempre deben informar a su médico o tecnólogo.*

MAMMOGRAM / MAMOGRAFÍA

- **If you are lactating or think you are pregnant, please notify the technologist.** *Si está lactando o cree que está embarazada, notifique al técnico por favor.*
- **Do not use powder, deodorant, or perfume on day of exam. Please wear a two piece outfit for your convenience.** *No use talco, desodorante o perfume en el día del examen. Por favor, use un traje de dos piezas para su conveniencia.*
- **Please bring previous mammograms if performed at another institution.** *Por favor traer mamografías anteriores que hayan sido realizadas en otra institución.*

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