



INDEPENDENCE PARK

SOUTHPOINT

Patient's name: \_\_\_\_\_ DOB: \_\_\_\_\_ Call to schedule? Y N

Mobile #: \_\_\_\_\_ Alternate #: \_\_\_\_\_ Insurance: \_\_\_\_\_

Appointment date: \_\_\_\_\_ Appointment time: \_\_\_\_\_ Authorization: \_\_\_\_\_

MRI   OPEN BORE MRI* COMPUTED TOMOGRAPHY (CT)		RADIOGRAPHIC PROCEDURES	ULTRASOUND
<b>CONTRAST:</b> <input type="radio"/> With <input type="radio"/> Without <input type="radio"/> With & w/o <input type="radio"/> If Needed <small>Recent Creatinine levels are required for ALL diabetic patients in addition to patients over age 50.</small> Creatinine: _____ Date Drawn: _____ Range: _____ <input type="radio"/> I-STAT Creatinine as needed.		X-rays performed on a walk-in basis. No appointment necessary.	<input type="radio"/> Abdomen Complete <input type="radio"/> Abdomen Limited <input type="checkbox"/> RUQ <input type="checkbox"/> Single Organ _____ <input type="radio"/> Aorta <input type="radio"/> Appendix <input type="radio"/> Breast Bilateral L R <input type="radio"/> Carotid <input type="radio"/> OB <input type="radio"/> 1 <sup>st</sup> Trimester <small>(Transabdominal /transvaginal as needed)</small> <input type="radio"/> 2 <sup>nd</sup> Trimester <small>(Transabdominal /transvaginal as needed)</small> <input type="radio"/> 3 <sup>rd</sup> Trimester <input type="radio"/> Pelvic <small>(Transabdominal and transvaginal as required)</small> <input type="radio"/> Renal/Bladder <input type="radio"/> Testicular (Scrotum) <small>(doppler for arterial inflow and venous outflow as required)</small> <input type="radio"/> Thyroid (Neck) <input type="radio"/> Venous <input type="checkbox"/> Lower Ext L R <input type="checkbox"/> Upper Ext L R <input type="radio"/> Other
MRI	CT	<input type="radio"/> Abdomen- 1 view supine (KUB) <input type="radio"/> Abdomen- 2 views supine & upright <input type="radio"/> AC Joints <input type="radio"/> Acute Abdominal Series (3 views) <input type="radio"/> Ankle L R <input type="radio"/> Bone Survey <input type="radio"/> Calcaneus (heel) L R <input type="radio"/> Chest <input type="radio"/> Clavicle L R <input type="radio"/> Elbow L R <input type="radio"/> Facial Bones <input type="radio"/> Femur L R <input type="radio"/> Finger L R <input type="radio"/> Foot L R <input type="radio"/> Forearm L R <input type="radio"/> Hand L R <input type="radio"/> Humerus L R <input type="radio"/> Hip L R <input type="radio"/> Knee L R <input type="radio"/> Mandible <input type="radio"/> Nasal Bones <input type="radio"/> Neck, Soft Tissue <input type="radio"/> Orbits <input type="radio"/> Pelvis <input type="radio"/> Ribs L R <input type="radio"/> Sacrum/Coccyx <input type="radio"/> Scapula L R <input type="radio"/> Scoliosis Series <input type="radio"/> Shoulder L R <input type="radio"/> SI Joints <input type="radio"/> Skull <input type="radio"/> Spine <input type="radio"/> Standing <input type="radio"/> Flexion/Extension <input type="checkbox"/> Cervical w/Obliques <input type="checkbox"/> Cervical AP/LAT Only <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar AP/LAT Only <input type="checkbox"/> Lumbar w/obliques <input type="radio"/> Sternum <input type="radio"/> Tibia/Fibula L R <input type="radio"/> Toe L R <input type="radio"/> Wrist L R	<b>MAMMO/BREAST US</b> <input type="radio"/> Screening - Bilateral <input type="radio"/> Screening - 3D Mammogram <input type="checkbox"/> Diagnostic if needed <input type="checkbox"/> Ultrasound if needed <input type="radio"/> Diagnostic - Bilateral <small>(To include US if needed)</small> <input type="radio"/> Unilateral L R <small>(To include US if needed)</small> Reason _____ <input type="radio"/> Ultrasound Y N <input type="radio"/> Breast MRI <input type="radio"/> Stereotactic/Ultrasound Breast Biopsy L R <input type="radio"/> Breast MRI Biopsy L R <input type="radio"/> Other
<input type="radio"/> Arthrogram <input type="radio"/> Abdomen* <input type="checkbox"/> Adrenals* <input type="checkbox"/> Liver* <input type="checkbox"/> Renal* <input type="radio"/> Ankle* L R <small>(to include hindfoot)*</small> <input type="radio"/> Foot* <input type="checkbox"/> Hindfoot to Midfoot* <input type="checkbox"/> Midfoot to Forefoot* <input type="radio"/> Brachial Plexus* L R <input type="radio"/> Brain* <input type="checkbox"/> Orbits <input type="checkbox"/> Pituitary <input type="checkbox"/> IAC <input type="radio"/> NeuroQuant <input type="radio"/> Breast MRI <input type="radio"/> Breast MRI Biopsy L R <input type="radio"/> Enterography <input type="radio"/> Hand/Finger* L R <input type="radio"/> Hips* L R <input type="radio"/> Knee* L R <input type="radio"/> MRA - Abdominal Aorta <input type="radio"/> MRA - Brain (Circle of Willis)* <input type="radio"/> MRA - Carotids (Cervical) <input type="radio"/> MRA - Thoracic Aorta <input type="radio"/> MRCP - (MR Cholangiogram) <input type="radio"/> Pelvis* <input type="radio"/> Shoulder* L R <input type="radio"/> Soft Tissue Neck <small>(structures other than c-spine)</small> <input type="radio"/> Spine* ___ C-Spine* ___ T-Spine* ___ L-Spine* <input type="radio"/> TMJ* <input type="radio"/> Wrist* L R <input type="radio"/> Other* (specify)	<b>Head</b> <input type="radio"/> Facial Bones <input type="radio"/> Head <input type="radio"/> CTA Head - Circle of Willis <input type="radio"/> Full Routine Sinus <input type="radio"/> Orbits <input type="radio"/> Paranasal Sinus Stereotactic Protocol: <input type="checkbox"/> Stealth <input type="checkbox"/> Fusion <input type="checkbox"/> Stryker <input type="radio"/> Temporal Bones <input type="radio"/> Neck - Soft Tissue <input type="radio"/> CTA Neck - Carotid Arteries <input type="radio"/> CTA Head/Neck-Pulsatile Tinnitus <b>Chest CT (w/ or w/o only)</b> <input type="radio"/> Chest <input type="radio"/> Chest - Hi Res/Interstitial Lung <input type="radio"/> CTA Chest - Pulmonary Embolus <input type="radio"/> CTA Chest/Abdomen - Aorta <b>Abdomen/Pelvis</b> <input type="radio"/> Enterography <input type="radio"/> Routine <input type="radio"/> Renal Mass Protocol <input type="radio"/> Stone Protocol <input type="radio"/> Abdomen Only, No Pelvis <input type="radio"/> Pelvis Only, No Abdomen <b>Spine (w/Sagittal/Coronal Reconstruction)</b> <input type="radio"/> Cervical <input type="radio"/> Thoracic <input type="radio"/> Lumbar <b>Extremity</b> <input type="radio"/> Upper L R <input type="radio"/> Lower L R <input type="radio"/> CTA Run off <b>Specialty Exams</b> <input type="radio"/> Coronary Calcium Scoring <b>Perform 3-D, SAG, COR Reconstruction (if necessary):</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Other	<b>FLUORO PROCEDURES</b> <input type="radio"/> Arthrogram Type <input type="radio"/> Barium Enema <input type="radio"/> Chest Fluoroscopy <input type="radio"/> Esophagus Barium Swallow <input type="radio"/> Modified (Barium Swallow) <input type="radio"/> Small Bowel Series <input type="radio"/> Upper GI Series <input type="radio"/> Other	<b>REPORT DELIVERY</b> <input type="radio"/> STAT <input type="radio"/> Routine <input type="radio"/> Call Report Contact Phone #: _____ <b>SEND IMAGES</b> <input type="radio"/> To Referring Provider <input type="radio"/> To Referring Provider w/pt. <input type="radio"/> Powershare
<b>DEXA/BONE DENSITOMETRY</b> <input type="radio"/> Bone Density Diagnosis: _____			

Insurance (Please fax front and back of patient's card and any clinical information to 877.765.7729)

Clinical indications/Signs/Symptoms: \_\_\_\_\_

Provider name (printed): \_\_\_\_\_ Provider signature: \_\_\_\_\_

Office phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Date: \_\_\_\_\_

# PATIENT INSTRUCTIONS

BRING THIS ORDER WITH YOU TO YOUR SCHEDULED EXAM

VISIT US ONLINE AT [WWW.NCDIAGNOSTICIMAGING.COM](http://WWW.NCDIAGNOSTICIMAGING.COM) FOR DRIVING DIRECTIONS AND TO LEARN MORE ABOUT OUR IMAGING FACILITY AND SERVICES.

## Center Information

### Independence Park



4323 Ben Franklin Blvd. Durham, NC 27704  
(919) 471-4840 **Phone**  
(919) 471-9345 **Fax**

### Southpoint



5107 Southpark Dr. Ste 101 Durham, NC 27713  
(919) 544-7199 **Phone**  
(919) 544-2621 **Fax**

## COMPUTED TOMOGRAPHY (CT)

- Brain/Neck/Chest**  
Nothing to eat or drink for 1 hour before exam,
- Abdomen/Pelvis**  
Nothing to eat for 4 hours or drink for 90 minutes before exam.
- CT Enterography**  
NPO 12 hours prior. Clear liquids (non carbonated) only after midnight.  
Check in 1 hour prior (CANNOT pickup contrast ahead of time.  
Wear comfortable, warm clothing (no metal).

ALL OTHER STUDIES REQUIRE NO PREPARATION.

## MAGNETIC RESONANCE IMAGING (MRI)

No prep for MRI exam. MRI cannot be performed on patients with a Cardiac Pacemaker, some Cardiac Valves and Stents, Otologic Implants, implanted Neurostimulator, Non-titanium Aneurysm Clips in head, Pregnancy (in some cases). Please bring any relevant outside X-Rays or other exams for correlation. This is especially important for Spine and Musculoskeletal MRI Exams.

- MRI Enterography**  
NPO 6 hours  
Arrive 1 hour prior to drink contrast
- MRI Abdomen**  
NPO 4 hours

## ULTRASOUND

- Abdomen/Gallbladder**  
For morning appointments, nothing by mouth after midnight. For all other appointments, nothing by mouth 5 (five) hours prior to examination.
- Kidneys** - no prep.
- Aorta** - Nothing to eat or drink 4 (four) hours before the examination.
- Appendix** - No prep.
- Pylorus** - Bring bottle of Pedialyte. Hold last feeding 2 (two) hours.
- Thyroid** - No prep.
- Carotid Artery** - No prep.
- Testicle** - No prep.
- Venous Doppler** - No prep.
- Breast** - No prep.
- Pelvic**
  1. Complete drinking four 8oz. glasses of water 1 (one) hour before scheduled examination.
  2. Do not empty bladder until after exam.
- OB**
  - 1st and 2nd Trimester: Same as Pelvic.
  - 3rd Trimester: 16 oz. water 1 (one) hour before exam. Hold bladder.

## FLUOROSCOPY

- Barium Swallow**  
No prep.
- Upper GI**  
Nothing by mouth after midnight.
- Small Bowel**  
Nothing by mouth after midnight.
- Barium Enema** - Bowel Preparation with Miralax and Dulcolax

**ONE DAY BEFORE THE EXAM:** You will need to purchase from the pharmacy: (4) Dulcolax 5 mg oral laxative tablets (not suppositories), one 238 gram bottle of Miralax (available without a prescription), and a 64 oz bottle of Gatorade or Crystal Light. Refrigerate the bottle of Gatorade or Crystal Light, as the solution is more palatable if cold.

### \*\*Diabetic Patients please use Crystal Light\*\*

Drink only clear liquids for breakfast, lunch and dinner. Clear liquids include strained fruit juices without pulp (apple, white grape, and lemonade), water, clear broth or bouillon, coffee, tea, Gatorade, sodas, Jell-O, and ice popsicles. NOT ALLOWED: Solid foods, milk or milk products, red or purple liquids.

**3:00pm** -Take 4 Dulcolax 5 mg oral tablets

**5:00pm** -Mix 238 gram bottle of Miralax in 64 oz of Gatorade or Crystal Light. Shake or stir the solution until the Miralax is dissolved. Drink an 8oz glass every 10-15 minutes until the solution is gone. If you become nauseated, please slow down drinking the solution and the nausea should pass.

**7:00pm – 9:00pm**-Drink at least 8 fl.oz of clear liquid every hour. Please note that the more clear liquid that you are able to drink; the more likely you are to have a good preparation.

### NOTHING TO EAT OR DRINK AFTER MIDNIGHT

**DAY OF EXAM** You may take Heart Medications including Blood Pressure Medication as directed by your Physician.

## MAMMOGRAPHY

Please wear a two-piece outfit. No underarm deodorant, antiperspirant, perfume, or powder on the day of the exam.

## DEXA PREP

Do not take calcium supplements 24 hours prior to appointment.

## PEDIATRIC EXAMINATION

Call Durham Diagnostic Imaging, 919-479-XYRAY (9729), for instructions.



**Durham Diagnostic Imaging**  
Independence Park | Southpoint  
[www.NCDIAGNOSTICIMAGING.COM](http://WWW.NCDIAGNOSTICIMAGING.COM)