**DIAGNOSTIC IMAGING REFERRAL FORM**

Date: ________________  Patient’s Name: ________________  DOB: ________________

Insurance: ___________________  Patient Phone: ___________________

Physician comments: ___________________

Diagnosis Code/Reason for Exam: ___________________

Print Physician Name: ___________________  Physician Signature: ___________________  Phone: ________________

### X-RAY: (please check and/or circle)

- [ ] Chest
- [ ] Extremity: ___________________ L/R
- [ ] Abdomen
- [ ] Pelvis
- [ ] Spine: Cervical 3 view  5 view
- [ ] Lumbar 3 view  5 view
- [ ] Thoracic 2 view
- [ ] Other: ___________________

### CT:

- [ ] Chest
- [ ] Abdomen
- [ ] Pelvis
- [ ] Head
- [ ] Sinuses
- [ ] Soft Tissue Neck
- [ ] Spine - C T L CT Angio
- [ ] Extremity: ___________________ L/R
- [ ] Other: ___________________

### MRI:

- [ ] Abdomen
- [ ] Brain
- [ ] Extremity: ___________________ L/R
- [ ] Other: ___________________

### PET:

- [ ] Oncology - Cancer type: ___________________
- [ ] Other: ___________________

### DIGITAL MAMMOGRAM:

- [ ] Screening
- [ ] Breast Implants (Includes 3D if indicated)
- [ ] Diagnostic
- [ ] Unil
- [ ] Bilat (Includes 3D if indicated)

### SPECIALTY BREAST EXAM:

- [ ] Ultrasound (indicate area on drawing)
- [ ] MRI Breast
- [ ] Breast Biopsy
  - [ ] Stereotactic
  - [ ] Ultrasound Guided
  - [ ] MRI Guided
- [ ] DEXA SCAN
  - [ ] Bone Density
  - [ ] Vertebral Fracture Assessment (VFA)

### ULTRASOUND:

- [ ] Abdominal (Attention to: ___________________)
- [ ] Renal
- [ ] Pelvic (w/ endovaginal)
- [ ] OB  ________________  Twins
- [ ] Thyroid
- [ ] Carotid
- [ ] Scrotum
- [ ] Soft Tissue: ___________________

Please ask the patient the following question to rule out contraindications to the exam:

Is she pregnant?  [ ] Yes  [ ] No  

For MRI: Does the patient have a pacemaker or aneurysm clip(s)?  [ ] Yes  [ ] No

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