ARA DIAGNOSTIC IMAGING

SCHEDULE MOST EXAMS ONLINE AT AUSRAD.COM/SCHEDULING
PHONE SCHEDULING 512.453.6100
Scheduling Hours: 7AM–7PM • Fax: 512.836.8869

ARA ADULT REFERRAL (ENGLISH)

SCHEDULING | LOCATIONS

PATIENT NAME Last First MI **DOB (MM/DD/YYYY)**

PATIENT PREFERRED PHONE **PATIENT EMAIL**

DIAGNOSIS **ICD 10 CODE(S)**

SPECIAL INSTRUCTIONS

REFERRING PHYSICIAN **NPI** **SIGNATURE** **DATE ORDERED**

INSURANCE & AUTHORIZATION # **APPT DAY** **APPT TIME**

EXAM PRIORITY

☐ **ROUTINE EXAM**

☐ **STAT EXAM** - Clinicians will be called when there are critical or significant unexpected findings, as determined by our radiologists.
Clinician contact number: _____
Fax STAT clinical notes to 512.977.8200

☐ Report needed for follow-up appt. Date: _____

☐ Additional report to: _____

X-RAY

CHECK AUSRAD.COM/X-RAY FOR WALK-IN AVAILABILITY

☐ Abdomen ○ 1 view ○ 2 view
☐ Chest ○ 1 view ○ 2 view
☐ Ribs ○ 2 view ○ 3 view ○ Left ○ Right
☐ Skull ○ 2 view ○ 4 view
☐ Sinus ○ 1 view ○ 2 view ○ 3 view
☐ Cervical spine ○ 1 view ○ 2 view ○ 3 view ○ 4 view ○ 5 view ○ Flex / ext
☐ Lumbar spine ○ 1 view ○ 2 view ○ 3 view ○ 4 view ○ 5 view ○ Flex / ext
☐ Thoracic spine ○ 1 view ○ 2 view ○ 3 view
☐ Scoliosis ○ 1 view ○ 2 view
☐ Pelvis ☐ Hip ○ Left ○ Right
☐ Sacroiliac ☐ Facial bones
☐ Sacrum / coccyx ☐ Mandible
☐ Leg length ☐ Orbits
☐ Bone age ☐ Nasal bones
☐ Foreign body - nose to rectum ☐ Soft tissue neck / adenoids
☐ Skeletal survey - MUST BE SCHEDULED
☐ Upper extremity ○ Left ○ Right ○ Specify _____
☐ Lower extremity ○ Left ○ Right ○ Specify _____
☐ IVP ○ Complete w tomosynthesis ○ Limited
☐ Other - specifiy _____

BONE DENSITOMETRY

☐ Bone densitometry ○ Hip / spine ○ Wrist / radius

MRI

SCREENING ORBITS WILL BE PERFORMED AS NECESSARY.
☐ Contrast at discretion of radiologist ☐ Do not administer IV contrast

HEAD
☐ Brain ☐ IACs ☐ Orbits
☐ Pituitary ☐ Skull base / face ☐ TMJ
☐ Soft tissue neck

SPINE
☐ Cervical ☐ Brachial plexus ○ Left ○ Right
☐ Thoracic ☐ Sacral plexus ☐ Lumbar

CHEST
☐ Chest

ABDOMEN
☐ Routine
☐ w MRCP & 3D - must list secondary diagnosis _____
☐ w Elastography
☐ Urogram (includes pelvis) ☐ Enterography (includes pelvis)

PELVIS
☐ Routine ☐ MSK pelvis ☐ Prostate (include PSA)
☐ Rectum ☐ Defecography

EXTREMITY SELECT LATERALITY ○ LEFT ○ RIGHT
☐ Arthrogram - specify joint: _____
☐ Long bone - specify ○ Humerus ○ Forearm ○ Femur ○ Tib / fib
☐ Shoulder ☐ Pectoralis ☐ Elbow ☐ Wrist
☐ Hand ○ Finger _____
☐ Hip ☐ Knee ☐ Ankle
☐ Foot ○ Toe _____

☐ **MRA** ☐ **MRV**
☐ Head ☐ Neck ☐ Chest ☐ Abdomen ☐ Pelvis
☐ Run-off (bifurcation to ankle)
☐ Upper extremity - specify _____
☐ Lower extremity - specify _____

For MRI and CT contrast studies, creatinine testing will be performed for patients meeting contrast screening guidelines.

OTHER / INTERVENTIONAL

☐ IVP with ultrasound as needed ☐ Uterine fibroid treatment consult
☐ Prostate artery embolization treatment consult
☐ Other _____

ARTHROGRAM w CT TO FOLLOW

☐ Arthrogram w CT to follow - specify joint _____

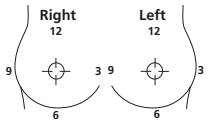
MOLECULAR IMAGING & NUCLEAR RADIOLOGY

☐ Bone scan ○ w SPECT/CT (area) _____
○ Total bone ☐ Limited (area) _____
○ 3-phase for infection / osteomyelitis, loose hardware (area) _____
☐ Brain SPECT/CT ○ Neurolite ○ DaTScan
☐ Gastric emptying scan
☐ HIDA scan with GBEF (gallbladder ejection fraction)
☐ I-123 MIBG w SPECT/CT
☐ I-123 whole body scan ○ w SPECT/CT ○ w Thyrogen
☐ Lymphoscintigraphy ○ w SPECT/CT ○ Injection only
☐ Liver spleen scan
☐ Liver SPECT/CT (RBC tag) for hemangioma
☐ Heat damaged RBC w SPECT/CT
☐ Meckel's scan w SPECT/CT
☐ MUGA scan for LVEF (resting only)
☐ Parathyroid scan w SPECT/CT ○ w ultrasound
☐ Renal scan w diff function ○ w Lasix ○ Cortical imaging
☐ Salivary glands
☐ Thyroid scan w uptake ○ Thyroid scan only
☐ Radioiodine treatment for hyperthyroidism
☐ Radioiodine treatment for cancer ○ w Thyrogen
☐ Radioiodine I-131 post treatment scan: 5-10 days post TX
☐ White blood cell (WBC) scan for infection w SPECT/CT (w marrow mapping if needed)
☐ Other _____

BREAST IMAGING

SCREENING
☐ Screening 3D mammogram w US or 3D diagnostic mammo if inconclusive
☐ Screening 3D mammogram
Radiologist approval required for screening mammo in patients under 30.
Screening ultrasound (dense breast / asymptomatic)
☐ Automated (ABUS) ☐ Handheld

NOTE AREA OF CONCERN REQUIRED FOR DIAGNOSTIC EXAMS



DIAGNOSTIC
☐ Complete diagnostic mammography workup w 3D (May include US, biopsy and / or cyst aspiration if needed)
☐ Diagnostic 3D mammo w US if needed ○ Female 30+ ○ Male 25+
☐ Diagnostic ultrasound w 3D mammo if needed
○ Female <30 ○ Male <25 (Indicate area of concern.)
☐ Ultrasound axilla w 3D mammo if needed

BREAST MRI
☐ Diagnostic w/wo contrast (Indicate area of concern.)
☐ Abbreviated screening
☐ Implant evaluation w/o contrast (silicone only)

BIOPSY (w post-biopsy mammogram if needed)
☐ Stereotactic ☐ Stereotactic w 3D ☐ Ultrasound ☐ MRI
☐ Radiologist to determine method

☐ Other _____

FLUOROSCOPY

☐ Hysterosalpingogram (HSG)
(Patient to abstain from intercourse from cycle day 1)
☐ Lumbar puncture ○ w pressures ○ w/o pressures
○ w lab work ○ w/o lab work
PLEASE ATTACH LAB ORDERS
☐ Steroid injection ○ Kenalog 40mg/ml ○ Depo-Medrol 80 mg/ml
Specify joint _____
☐ Joint aspiration - specify joint _____
PLEASE ATTACH LAB ORDERS
☐ Other _____

MYELOGRAM w CT TO FOLLOW

☐ Cervical ☐ Lumbar
☐ Thoracic ☐ Entire spine ☐ Other _____

CT

CT NEURO Specify IV contrast ☐ without ☐ with ☐ PRN

HEAD
☐ Brain ☐ Facial bones ☐ Orbits ☐ Craniofacial
☐ Temporal bones
☐ Sinus ○ Complete
○ Surgical navigation - specify _____
☐ Soft tissue neck

SPINE
☐ Cervical ☐ Lumbar ☐ Thoracic
☐ Other - specify _____

CTA NEURO - CONTRAST REQUIRED
☐ Intracranial (head) ☐ Carotid (neck)
☐ CT-venogram--intracranial (head)
☐ Other - specify _____

CT BODY Specify IV contrast ☐ without ☐ with ☐ PRN
Chest ☐ Routine ☐ Interstitial lung disease (w/o contrast) ☐ Airway
☐ Surgical navigation - specify _____
☐ Abdomen only
☐ Abdomen (w pelvis if needed) ☐ Pelvis only
☐ Abdomen & pelvis ○ Enterography / small bowel w 3D
○ Renal calculi (w/o contrast)
○ Urogram (CT-IVP / hematuria protocol)
☐ Virtual colonoscopy ○ Screening (asymptomatic)
○ Diagnostic (symptomatic)
☐ Cardiac CT calcium scoring (screening, no contrast required)
Note any symptoms _____
☐ Other _____

CT EXTREMITY Specify IV contrast ☐ without ☐ with ☐ PRN
☐ Specify _____ ☐ Left ☐ Right
☐ Surgical navigation - specify _____

CTA BODY - CONTRAST REQUIRED
☐ Chest ○ Pulmonary embolism
☐ Abdomen
☐ Abdomen/pelvis ○ Aortic pre-stent
○ Aortic post-stent
○ Perforator protocol
○ w runoff
☐ Pelvis
☐ Venogram ○ Abdomen / pelvis ○ Pelvis
☐ Other _____

- **CT lung screening form available at ausrad.com/downloads.**
- If CT & PET are needed, providers can call scheduling at 512.458.9098.
- Contrast and additional views at discretion of radiologist.

PET/CT

SEPARATE FORM REQUIRED. CALL 512.453.6100 TO SCHEDULE.

ULTRASOUND

ABDOMEN
☐ Abdominal organs - complete
☐ Abdominal organs - limited to _____
☐ Liver elastography ☐ Renal ☐ Aorta

PELVIC
☐ Pelvic transabdominal & transvaginal ☐ Testicular (includes Doppler)
☐ Pelvic (transvaginal only) ☐ Groin
☐ Pelvic (transabdominal only) ☐ Bladder ○ w PVR

OBSTETRICAL (<14 weeks only)
☐ OB transabdominal & transvaginal ☐ OB transvaginal only
☐ OB transabdominal only

NECK
☐ Thyroid ☐ Neck - soft tissues only

VASCULAR ULTRASOUND
☐ Carotid Doppler ☐ ABI only (limited NIPS)
☐ Arterial duplex (complete NIPS) ○ Arms ○ Legs
☐ Venous Doppler legs ○ Left ○ Right
☐ Venous Doppler arms ○ Left ○ Right

ARA DIAGNOSTIC IMAGING

EXAMINATION INSTRUCTIONS

IVP*

1. The day before your exam, drink six (6) to eight (8) 8-ounce glasses of clear liquid between lunch and dinner.
2. The evening before your exam, eat a light dinner. Limit the meal to items such as a small sandwich, Jell-O or soup. Do not eat or drink any dairy products.
3. Between 5:00 p.m. and 9:00 p.m., take two (2) Dulcolax or Bisacodyl USP tablets.
   NOTE: DO NOT TAKE DULCOLAX OR BISACODYL TABLETS WITHIN ONE HOUR OF DRINKING MILK OR TAKING ANTACID.
4. After midnight, DO NOT have anything else to eat until after your exam. You may drink clear liquids before your exam.

PELVIC/OB ULTRASOUND*

1. One hour before your exam starts, finish drinking 32 ounces of water. BLADDER MUST BE FULL FOR EXAM.
2. DO NOT empty bladder until after your exam.

ABDOMINAL ULTRASOUND

1. Morning exams: After midnight, do not have anything to eat or drink until after your exam.
2. Afternoon exams: Eat a LOW-FAT BREAKFAST before 8:00 a.m. (no milk, butter, cream, cheese, peanut butter), then nothing else to eat or drink before the exam.

RENAL ULTRASOUND*

1. Thirty (30) minutes before your exam, finish drinking 24 ounces of water.
2. DO NOT empty bladder until after your exam.

MAMMOGRAM

1. Before your exam, clean the breasts thoroughly.
2. DO NOT use deodorants or powders in the underarms or areas around the breasts. Rubbing alcohol can be used as an antiperspirant.
3. It is recommended that you wear a two-piece outfit.

CT

You will be given preparation instructions, if any, when you schedule. They can also be sent to you by email.

*Patients on fluid restrictions should consult their physicians for instructions.

LOCATIONS

SCHEDULING

WALK-IN X-RAY

WALK-IN X-RAY AVAILABILITY