



**MRI**  
 626-966-8884  
 626-966-8804 fax  
 266 W. College St.  
 Covina, CA 91723

**CT, X-Ray,  
 Ultrasound**  
 626-732-9882  
 626-732-9617 fax  
 605 E. Badillo St.  
 Covina, CA 91723

Patient Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ M F

Diagnosis or brief clinical info: \_\_\_\_\_

Referring MD: \_\_\_\_\_ Date Ordered: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Fax # \_\_\_\_\_

- X-RAY\***       **Right**       **Left**
- Skull
  - Facial
  - Sinus
  - Nasal Bone
  - Mandible
  - Sternum
  - Ribs
  - Abd Series
  - KUB
  - Pelvis
  - Hip
  - Other \_\_\_\_\_
- Humerus
  - Femur
  - Knee
  - Ankle
  - Tibia/Fibula
  - Foot
  - Heel
  - Toe
  - Chest
  - Clavicle
  - Shoulder
- Hand
  - Forearm
  - Wrist
  - Elbow
  - Finger
  - Cervical Spine
  - Thoracic Spine
  - Lumbar Spine
  - Sacrum-Coccyx
  - SI Joints
  - Soft Tissue Neck

\* **NO APPOINTMENT NECESSARY\***  
 8:00a.m. – 6:00p.m. Monday - Friday

- MRI (APPOINTMENT REQUIRED)**
- Right**       **Left**      **GADOLINIUM**     **Y**     **N**
  - Brain
  - Cervical
  - Lumbar
  - Orbits
  - Pelvis
  - Wrist
  - Shoulder
  - Soft Tissue Neck
  - MRA Head
  - Other \_\_\_\_\_
  - IAC
  - Pituitary
  - Thoracic
  - Sinus
  - Hip
  - Knee
  - Ankle
  - Foot

- ◆ Arrive 30 minutes prior to your appointment
- ◆ Bring previous x-ray, CT, or MRI films, if available
- ◆ Be sure to bring your insurance forms/card.
- ◆ Notify us 24 hours in advance if you are unable to keep your appointment

**PLEASE FAX MRI REQUEST TO (626)966-8804**

- ULTRASOUND (APPOINTMENT REQUIRED)**
- Arterial Segmental Pressures     RLE     LLE     Bilat. LE
  - Venous Doppler     RLE     LLE     Bilat. Lower Extremity
  - Carotid Duplex       Renal (Kidneys/Bladder)
  - Thyroid       Testicular/Scrotum
  - Abdominal Aorta       Abdomen-General
  - Pelvic/Transvaginal       Other \_\_\_\_\_
  - OB Trimester     1<sup>st</sup>     2<sup>nd</sup>     3<sup>rd</sup>

***NO Cardiac Echos or Breast Ultrasounds***

- ◆ Abdominal studies – nothing to eat after midnight, the night before the exam date.
- ◆ Renal/Pelvic/OB studies – drink 32 oz of water 45 min - 1 hr before the appointment time, without urinating.
- ◆ Bring insurance forms/card
- ◆ Arrive 20minutes before your appointment and notify us 24 hours in advance if you cannot keep your appointment.

**PLEASE FAX ULTRASOUND REQUESTS TO (626)732-9114**

- C.T. (APPOINTMENT REQUIRED)**
- I.V. CONTRAST\***       **Y**       **N**
- \*Date of Service of Labs( within 30 days) \_\_\_\_\_
- \*MUST PROVIDE B.U.N. \_\_\_\_\_ Creatinine \_\_\_\_\_
- Head
  - Sinus
  - Mastoid/Temporal
  - Abdomen
  - Chest
  - Abd. Aorta Angio (no oral prep)
  - Joint/Extremities –specify \_\_\_\_\_
  - Other \_\_\_\_\_
  - Soft Tissue Neck
  - Facial Bones
  - Cervical Spine
  - Thoracic Spine
  - Lumbar Spine

- ◆ If oral contrast is ordered, you must pick up the contrast at Covina Imaging, CT dept. one day prior to your appt.
- ◆ Bring a list of current medications, insurance card and CD/ films from any previous studies for comparison.
- ◆ Arrive 30 minutes prior your appointment.
- ◆ All studies with IV contrast – nothing to eat 4 hours prior to your appointment

**PLEASE FAX CT REQUEST TO (626)732-9617**

**BONE DENSITOMETRY (DEXA) SCAN**