

ORTHOPAEDICS



The Radiology Clinic, L.L.C.

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 Scheduling Fax 758-5888

Patient's Name: _____
 Appointment Date: _____ Time: _____
 Reason for Exam: _____
 Allergies: _____
 Referring Physician: _____, M.D.
 Patient may go home after exam. Please call report.
 Return patient to my office after exam. Please FAX report
 Other: _____

TYPE OF EXAM	PATIENT INSTRUCTIONS	REMARKS
GENERAL		
<input type="checkbox"/> Knee X-Ray	No prep	
<input type="checkbox"/> Other X-Ray		
MYELOGRAPHY		
<input type="checkbox"/> Cervical Myelogram	No food after midnight on the night before if exam is before 2:00 p.m. Light breakfast by 7:00 a.m. if exam is after 2:00 p.m.	
<input type="checkbox"/> Thoracic Myelogram		
<input type="checkbox"/> Lumbar Myelogram		
ULTRASOUND		
<input type="checkbox"/> Lower Extremity Venous	No prep	
<input type="checkbox"/> Lower Extremity Arterial	No prep	
<input type="checkbox"/> Other Ultrasound		
CT	ALERT TECHNOLOGIST TO ALLERGIC HISTORY	
<input type="checkbox"/> Leg	No prep	
<input type="checkbox"/> Cervical Spine	Clear liquid diet 4 hours prior to exam	
<input type="checkbox"/> Thoracic Spine	No prep	
<input type="checkbox"/> Lumbar Spine	No prep	
<input type="checkbox"/> Neck	Clear liquid diet 4 hours prior to exam	
<input type="checkbox"/> Other CT		
MRI		
<input type="checkbox"/> Cervical Spine	No prep	ATTENTION PATIENT PLEASE INFORM THE TECHNOLOGIST IF YOU HAVE A PACEMAKER OR ANY METAL PRESENT IN YOUR BODY OR HAVE HAD OPEN HEART SURGERY.
<input type="checkbox"/> Thoracic Spine	No prep	
<input type="checkbox"/> Lumbar Spine	No prep	
<input type="checkbox"/> MRA	No prep	
<input type="checkbox"/> Knee <input type="checkbox"/> Left <input type="checkbox"/> Right	No prep	
<input type="checkbox"/> Shoulder <input type="checkbox"/> Left <input type="checkbox"/> Right	No prep	
<input type="checkbox"/> Other MRI		
NUCLEAR MEDICINE		
<input type="checkbox"/> Bone Scan	Will receive injection and return 2-3 hours later	
OTHER		
<input type="checkbox"/> DEXA (Bone Density Study)	No multivitamins or calcium supplements day before & day of exam	
<input type="checkbox"/> Arthrogram, Shoulder	No prep	
<input type="checkbox"/> Other		