5219 N. McColl Rd.
McAllen, Texas 78504
Tel. (956) 800-4961
FAX: (956)800-4962

Patient Name: _____ DOB: _____

Appointment Date: _____ Time: _____ Phone #: _____

Physician: _____ Tel: _____ Fax: _____

☐STAT

*Contrast Studies for patients who are diabetic and / over 50 yrs. old require BUN/CREATININE lab work

MRI

CONTRAST: [ ] W/O [ ] WITH [ ] W&WO
[ ] RIGHT [ ] LEFT

[ ] ABDOMEN
[ ] ANKLE
[ ] BRAIN
[ ] CAROTID
[ ] CERVICAL SPINE
[ ] ELBOW
[ ] FOOT
[ ] HAND
[ ] HIP
[ ] IAC's
[ ] KNEE
[ ] LUMBAR SPINE
[ ] NECK SOFT TISSUE
[ ] ORBITS
[ ] PELVIC
[ ] PITUITARY GLAND
[ ] SACRUM / COCCYX
[ ] SHOULDER
[ ] SINUSES
[ ] THORACIC SPINE
[ ] TMJ's
[ ] WRIST
[ ] OTHER: _____
_____
_____

XRAY

[ ] RIGHT [ ] LEFT [ ] BILATERAL

[ ] ABD
[ ] ANKLE
[ ] CERVICAL SPINE
[ ] CHEST
[ ] CLAVICLE
[ ] ELBOW
[ ] FACIAL BONES
[ ] FEMUR
[ ] FINGER
[ ] FOOT
[ ] FOREARM
[ ] HAND
[ ] HIP
[ ] HUMERUS
[ ] KNEE
[ ] KUB
[ ] LUMBAR SPINE
[ ] MANDIBULE
[ ] NASAL BONE
[ ] ORBITS
[ ] PARANASAL SINUSES
[ ] PELVIS
[ ] RIBS
[ ] SACRUM / COCCYX
[ ] SHOULDER
[ ] SKULL
[ ] STERNUM
[ ] THORACIC SPINE
[ ] TIB-FIB
[ ] TMJ's
[ ] TOE
[ ] WRIST
[ ] OTHER:
_____
_____
_____

MRA

CONTRAST: [ ] W/O [ ] WITH [ ] W&WO

[ ] BRAIN [ ] CAROTIDS [ ] RENAL

OTHER

[ ] OTHER: _____
_____

LT RT ACUTE CHRONIC

DIAGNOSIS: _____

PHYSICIAN SIGNATURE: _____

Print Referring MD: _____ DATE: _____