

## Patient Instructions

1. Bring this prescription form with you on the day of the exam.
2. Dress in loose, comfortable two-piece clothing if possible. No belts, buckles or zippers.
3. For scheduled appointments arrive 30 minutes prior to your examination time.
4. If required, obtain pre-authorization from your insurance company to avoid unexpected costs, delays and cancellations.
5. Have your insurance card, prescription for the examination and proof of pre-authorization (if applicable) with you when you arrive.
6. Routine exams (No Appointment needed), can be done at the OUTPATIENT RADIOLOGY DEPARTMENT (Located at 24411 Health Center Drive, Suite 101, Laguna Hills, CA) Monday-Friday 7:30am – 4:30pm

### Study Instructions and Preparations

| Radiographic Studies:   |  |
|---|--|
| <b>IVP (Intravenous Pyelograms) and Barium Enemas</b>             | Prep Kit available in Radiology or instruction will be provided.<br>You are allowed to have two 8 ounce glasses of water or juice prior to your procedure.<br>You may take your morning medications (unless it must be taken with solid food).   |
| <b>Hysterosalpingogram</b>  | Must be done within 10 days of the first day of your last period. You cannot be bleeding at the time of this exam, if you are, call the Radiology Department at 949-452-3573.  |
| <b>UGI (Upper Gastrointestinal) Small Bowel Series Esophagram</b> | Nothing to eat or drink 8 hours prior to your examination—this includes gum, medications, breath mints.<br>If your exam includes a Small Bowel Series, please bring something to read, you will be in our department anywhere from 1 hour to 4 hours.                                  |
| CT Scans Studies:   |  |
| <b>Urogram</b>  | Drink 32 ounces of water 1 hour prior to your appointment.   |
| <b>Abdomen, Pelvis, Pancreas, Liver</b>                           | If oral contrast was ordered, pick this up in the Radiology Department at least one day prior to your scan. If you did not pick it up, please come to your appointment 1.5 hours early to drink this contrast.<br><b>YOU MAY DRINK FLUIDS ALL THE WAY UP TO YOUR APPOINTMENT TIME.</b> |
| <b>Studies that require IV contrast.</b>                          | If you are having intravenous contrast, <b>DO NOT</b> have <b>SOLID</b> food for 3 hours prior to your exam.<br><b>YOU MAY DRINK FLUIDS ALL THE WAY UP TO YOUR APPOINTMENT TIME.</b>   |
| Ultrasound Studies:   |  |
| <b>Abdomen</b>  | Nothing to eat or drink for 8 hours prior to your scheduled appointment.   |
| <b>Pelvic OB</b>  | You need a full bladder for this exam. Drink 32 ounces of clear liquids one hour prior to your appointment time.<br><b>DO NOT EMPTY YOUR BLADDER.</b>  |
| <b>Sonohysterogram</b>  | Sonohysterograms <b>MUST</b> be scheduled within 10 days of the start of your last period.   |
| <b>Renal</b>  | Drink two 8 ounce glasses of water 30 minutes prior to your exam   |
| Nuclear Medicine Exams:   |  |
| <b>HIDA, Cisternogram</b>   | Nothing to eat or drink 8 hours prior to your examination.   |
| <b>Myocardial studies</b>   | Nothing to eat or drink 2 hours prior to your examination  |
| <b>Bone Scan</b>  | Drink Plenty of fluids for 24 hours prior to your examination.   |
| <b>Gastric Emptying</b>   | Nothing to eat or drink 4 hours prior to your examination.   |
| <b>PET/CT</b>   | Do not eat anything 6 hours before your appointment. If you are diabetic, fast for 4 hours only. Drink 24 - 32 ounces of water prior to appointment. All oral medications can be taken. (No caffeine or sugar)   |
| <b>MRI</b>  | MRCP/Abdomen MRI: Nothing to eat six (6) hours before appointment. Take your usual medications. Clear liquids ok. (No caffeine or sugar). No jewelry.  |

### Outpatient Radiology

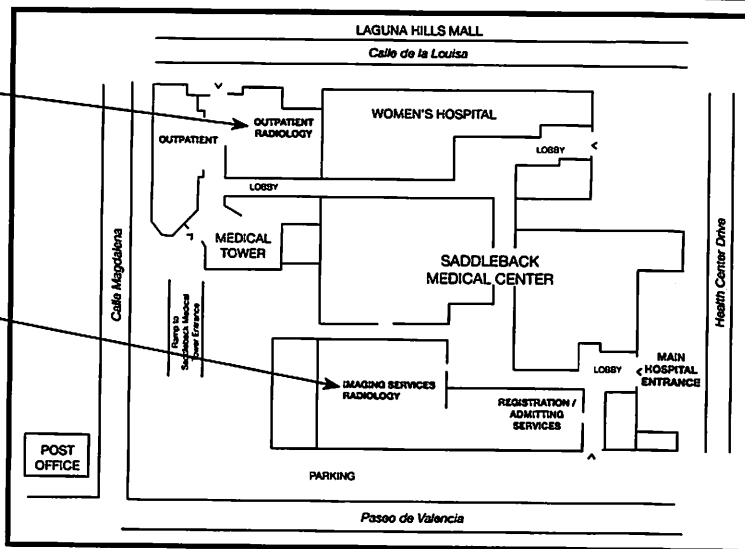
1st Floor – Medical Office Tower

ROUTINE: X-Ray, Ultrasound, Nuclear Medicine, CT Scan

### Main Radiology

1st Floor – Hospital

X-Ray, Ultrasound, Nuclear Medicine, CT Scan, Special Procedures



**Patients • Schedule Exam Call: (949) 452-3648 • Fax: (949) 452-3480**

**MD Offices • Schedule:  
Call: (949) 452-3132**

|  |   |   |                           |                  |
|--|---|---|---------------------------|------------------|
| Patient Name:  | M | F | Date of Birth (REQUIRED): | Phone #:         |
| Print Ordering Physician Name:   |   |   |                           |                  |
| PHYSICIAN SIGNATURE (REQUIRED):  |   |   |                           | Date (REQUIRED): |
| Physician Phone:   |   |   | Physician Fax:            |                  |
| <input type="checkbox"/> Call results STAT <span style="margin-left: 150px;"><input type="checkbox"/> Fax results to ordering physician</span> |   |   |                           |                  |
| Also send Results to:  |   |   |                           |                  |
| CLINICAL HISTORY / INDICATION FOR EXAM (REQUIRED):   |   |   |                           |                  |
| OTHER EXAM OR SPECIAL INSTRUCTIONS:  |   |   |                           |                  |

**DIAGNOSTIC X-RAYS: ALL FLUOROSCOPIC EXAMS LISTED BELOW MUST BE SCHEDULED**

**FLUOROSCOPIC EXAMS**

- |   |  |
|---|--|
| <input type="checkbox"/> Barium Enema                   | <input type="checkbox"/> UGI w/ Small Bowel Series   |
| <input type="checkbox"/> Barium Enema w/Air Contrast    | <input type="checkbox"/> Small Bowel Series Only     |
| <input type="checkbox"/> Water Soluble Enema            | <input type="checkbox"/> Cystogram (non-voiding)     |
| <input type="checkbox"/> Esophagram w/ Speech Therapist | <input type="checkbox"/> Cystogram Voiding (routine) |
| <input type="checkbox"/> Esophagram (routine)           | <input type="checkbox"/> Hysterosalpingogram         |
| <input type="checkbox"/> UGI                            |  |

**ROUTINE/WALK-IN**

- |   |  |
|---|--|
| <input type="checkbox"/> Abdomen (KUB)  | <input type="checkbox"/> Sinus Series              |
| <input type="checkbox"/> Abdomen 2 views  | <input type="checkbox"/> Sinus, Water's View Only  |
| <input type="checkbox"/> Chest X-ray 2 View   | <input type="checkbox"/> Ribs R L                  |
| <input type="checkbox"/> Chest X-ray 1 View   | <input type="checkbox"/> Hip R L (Includes Pelvis) |
| <input type="checkbox"/> Spine <input type="checkbox"/> C <input type="checkbox"/> T <input type="checkbox"/> L | <input type="checkbox"/> Knee R L                  |
| <input type="checkbox"/> Limited  | <input type="checkbox"/> _____                     |

**ULTRASOUND EXAMS: ALL EXAMS MUST HAVE AN APPOINTMENT**

- |                                   |                                  |   |  |   |
|-----------------------------------|----------------------------------|---|--|---|
| <input type="checkbox"/> Abdomen  | <input type="checkbox"/> Pelvic  | <input type="checkbox"/> Paracentesis       | <input type="checkbox"/> Sonohysterogram       | <input type="checkbox"/> Venous Lower Ext R L   |
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Renal   | <input type="checkbox"/> Thoro-centesis R L | <input type="checkbox"/> Other (specify above) | <input type="checkbox"/> Arterial Upper Ext R L |
| <input type="checkbox"/> Neck     | <input type="checkbox"/> Scrotal | <input type="checkbox"/> Biopsy Thyroid R L | <input type="checkbox"/> Carotids (NICE)       | <input type="checkbox"/> Arterial Lower Ext R L |
| <input type="checkbox"/> OB       | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Biopsy Liver       | <input type="checkbox"/> Venous Upper Ext R L  | <input type="checkbox"/> Aorta                  |

**MR IMAGING: ALL EXAMS MUST HAVE AN APPOINTMENT**

- No IV Contrast    With & Without IV Contrast    MRA    MRV
- |  |   |  |                                      |                                       |
|--|---|--|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Brain   | <input type="checkbox"/> Hip R L        | <input type="checkbox"/> Sacrum/Coccyx       | <input type="checkbox"/> MRCP        | <input type="checkbox"/> MRE          |
| <input type="checkbox"/> Pituitary   | <input type="checkbox"/> Knee R L       | <input type="checkbox"/> Brachial Plexus R L | <input type="checkbox"/> Abdomen     | <input type="checkbox"/> Brain        |
| <input type="checkbox"/> IAC   | <input type="checkbox"/> Ankle R L      | <input type="checkbox"/> Shoulder R L        | <input type="checkbox"/> Pelvis S.T. | <input type="checkbox"/> Carotid      |
| <input type="checkbox"/> Orbit   | <input type="checkbox"/> Foot/Toe R L   | <input type="checkbox"/> Elbow R L           | <input type="checkbox"/> Bony Pelvis | <input type="checkbox"/> Runoff       |
| <input type="checkbox"/> Neck S.T.   | <input type="checkbox"/> Humerus R L    | <input type="checkbox"/> Wrist R L           | <input type="checkbox"/> Chest       | <input type="checkbox"/> Defecography |
| Spine <input type="checkbox"/> C <input type="checkbox"/> T <input type="checkbox"/> L | <input type="checkbox"/> Arthrogram R L | <input type="checkbox"/> Hand/Finger R L     | <input type="checkbox"/> Cardiac     |                                       |

**CAT SCAN EXAMS: ALL EXAMS MUST HAVE AN APPOINTMENT**

- Contrast:**    None    Oral    IV    IV and Oral (See Prep instructions on back)
- |   |   |  |  |  |
|---|---|--|--|--|
| <input type="checkbox"/> Brain          | <input type="checkbox"/> Abdomen (stops at umbilicus) | <input type="checkbox"/> Neck for Soft Tissue          | <input type="checkbox"/> Biopsy (Please specify in special instructions) | <input type="checkbox"/> Abd/Pel CTA         |
| <input type="checkbox"/> Facial Bones   | <input type="checkbox"/> Abdomen w/ Pelvis            | <input type="checkbox"/> Cervical Spine                |  | <input type="checkbox"/> Brain CTA           |
| <input type="checkbox"/> Orbits         | <input type="checkbox"/> Chest/Abdomen/Pelvis         | <input type="checkbox"/> Thoracic Spine                | <b>CT ANGIOGRAMS</b>   | <input type="checkbox"/> Carotids CTA (neck) |
| <input type="checkbox"/> Sinus          | <input type="checkbox"/> Chest/Abdomen                | <input type="checkbox"/> Lumbar Spine                  | (Only IV contrast needed)  | <input type="checkbox"/> Chest CTA for PE    |
| <input type="checkbox"/> Temporal Bones | <input type="checkbox"/> Chest Only                   | <input type="checkbox"/> Urogram                       | <input type="checkbox"/> Abdomen CTA                                     | <input type="checkbox"/> Thoracic Aorta CTA  |
|   | <input type="checkbox"/> Pelvis Only                  | <input type="checkbox"/> LDCT (Lung Screen) (Low Dose) | <input type="checkbox"/> Abdomen w/Run off to legs                       | <input type="checkbox"/> Renal Artery CTA    |
|   |   |  | <input type="checkbox"/> CTA Cardiac                                     | <input type="checkbox"/> CTA Coronary/Artery |

**NUCLEAR MEDICINE EXAMS: ALL EXAMS NEED AN APPOINTMENT**

- |  |   |   |   |   |  |
|--|---|---|---|---|--|
| <input type="checkbox"/> Myocardial Rest/Stress                      | <input type="checkbox"/> MUGA                   | <input type="checkbox"/> Gastric emptying | <input type="checkbox"/> Gallium                | <input type="checkbox"/> Indium (WBC)       | <input type="checkbox"/> Thyroid Uptake and Scan |
| <input type="checkbox"/> Myocardial Rest/with Pharmacological Stress | <input type="checkbox"/> Bone Scan routine      | <input type="checkbox"/> Lung Scan (VQ)   | <input type="checkbox"/> HIDA Scan              | <input type="checkbox"/> Ceretec WBC        | <input type="checkbox"/> Renal                   |
|  | <input type="checkbox"/> Bone Scan Limited      | <input type="checkbox"/> Cisternogram     | <input type="checkbox"/> W/PHARM (Injection FX) | <input type="checkbox"/> Liver/Spleen Scan  | <input type="checkbox"/> Renal w/Lasix           |
|  | <input type="checkbox"/> Bone Scan Triple Phase | <input type="checkbox"/> Cystogram        | <input type="checkbox"/> W/O PHARM              | <input type="checkbox"/> Renal w/ Captopril |  |

**PET/CT EXAM: ALL EXAMS MUST HAVE AN APPOINTMENT**

- Skull base to thigh    Whole body (Melanoma)    Limited \_\_\_\_\_  
(Specify Area)