



**North Fulton Regional Hospital**  
 3000 Hospital Boulevard  
 Roswell, GA 30076  
 (770) 751-2720  
 (scheduling option #1; pre-admission option #2)  
 FAX: (770) 751-2905

**Roswell Imaging Center**  
 North Fulton Regional Hospital  
 2500 Hospital Boulevard  
 Suites 220 & 225  
 Roswell, GA 30076  
 (770) 751-2720 (scheduling option #1;  
 no pre-admission required)  
 FAX: (770) 751-2905

**Northwoods Medical Plaza**  
 1230 Bald Ridge Marina Rd.  
 Cumming, GA 30041  
 (770) 781-6350  
 FAX: (770) 781-6357

Patient Name \_\_\_\_\_ Appointment Date \_\_\_\_\_ Time \_\_\_\_\_

Referring Physician \_\_\_\_\_ Date of Birth \_\_\_\_\_

Office Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

**SPECIAL INSTRUCTIONS**

- STAT     Phone Report     Fax Report     Films with Patient     Other \_\_\_\_\_  
 Duplicate Report to (Name/Address): \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_ **Precert** No / Yes #: \_\_\_\_\_

**MRI (North Fulton Regional Hospital ONLY) (Indicate if with Arthrogram)**

<input type="checkbox"/> BRAIN <input type="checkbox"/> without & with Contrast <input type="checkbox"/> with Contrast ONLY <input type="checkbox"/> MRA Circle of Willis <input type="checkbox"/> MRA Carotids <input type="checkbox"/> IAC's <input type="checkbox"/> PITUITARY <input type="checkbox"/> BRACHIAL PLEXUS <input type="checkbox"/> NECK (Suprahyoid or Infrahyoid)	<input type="checkbox"/> CERVICAL SPINE <input type="checkbox"/> without & with Contrast <input type="checkbox"/> with Contrast ONLY <input type="checkbox"/> THORACIC SPINE <input type="checkbox"/> without & with Contrast <input type="checkbox"/> with Contrast ONLY <input type="checkbox"/> LUMBAR SPINE <input type="checkbox"/> without & with Contrast <input type="checkbox"/> with Contrast ONLY	<input type="checkbox"/> KNEE Right / Left <input type="checkbox"/> SHOULDER Right / Left <input type="checkbox"/> ANKLE Right / Left <input type="checkbox"/> HIP Right / Left <input type="checkbox"/> ELBOW Right / Left <input type="checkbox"/> WRIST Right / Left <input type="checkbox"/> TMJ's <input type="checkbox"/> MRCP	<input type="checkbox"/> LIVER <input type="checkbox"/> KIDNEYS <input type="checkbox"/> PANCREAS <input type="checkbox"/> ADRENAL GLANDS <input type="checkbox"/> SPLEEN <input type="checkbox"/> PELVIS <input type="checkbox"/> MRA Renal Arteries <input type="checkbox"/> OTHER _____
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**CT**

<input type="checkbox"/> BRAIN <input type="checkbox"/> without & with Contrast <input type="checkbox"/> with Contrast ONLY <input type="checkbox"/> Screening <input type="checkbox"/> SINUSES <input type="checkbox"/> Coronal ONLY <input type="checkbox"/> TEMPORAL BONES <input type="checkbox"/> ORBITS <input type="checkbox"/> FACIAL BONES	<input type="checkbox"/> THORAX <input type="checkbox"/> without I.V. Contrast <input type="checkbox"/> THORAX (High Resolution) <input type="checkbox"/> THORAX (Pulm. Embolus) <input type="checkbox"/> THORACIC AORTA <input type="checkbox"/> ABDOMENAL AORTA <input type="checkbox"/> LARYNX <input type="checkbox"/> NECK (Suprahyoid) <input type="checkbox"/> NECK (Routine)	<input type="checkbox"/> ABDOMEN (Routine) <input type="checkbox"/> without I.V. Contrast <input type="checkbox"/> ABDOMEN (Focused) Area of interest: _____ <input type="checkbox"/> KIDNEY STONE PROTOCOL <input type="checkbox"/> ABDOMEN (Tri-phasic Liver/Metastasis) <input type="checkbox"/> PELVIS <input type="checkbox"/> without I.V. Contrast	<input type="checkbox"/> CERVICAL SPINE <input type="checkbox"/> THORACIC SPINE <input type="checkbox"/> LUMBAR SPINE <input type="checkbox"/> JOINT: Right / Left _____ <input type="checkbox"/> BONE: Right / Left _____ <input type="checkbox"/> OTHER _____
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**Ultrasound**

<input type="checkbox"/> ABDOMEN (Routine/GB/RUQ) <input type="checkbox"/> ABDOMEN (One Organ): _____ <input type="checkbox"/> KIDNEYS	<input type="checkbox"/> PELVIS <input type="checkbox"/> Hysterosonogram <input type="checkbox"/> FETAL AGE (First Trimester) <input type="checkbox"/> OB (Specify exam) _____	<input type="checkbox"/> SCROTUM <input type="checkbox"/> BREAST Right / Left <input type="checkbox"/> THYROID <input type="checkbox"/> OTHER _____	<input type="checkbox"/> CAROTID <input type="checkbox"/> AORTA <input type="checkbox"/> VENOUS LOWER EXT Right / Left <input type="checkbox"/> VENOUS UPPER EXT Right / Left
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**Fluoroscopy**

<input type="checkbox"/> BARIUM ENEMA Air Contrast <input type="checkbox"/> BARIUM ENEMA Single Contrast/Gastrograffin	<input type="checkbox"/> UPPER GI <input type="checkbox"/> with/Small Bowel Follow Through <input type="checkbox"/> SMALL BOWEL SERIES <input type="checkbox"/> ESOPHAGRAM	<input type="checkbox"/> CYSTOURETHROGRAM <input type="checkbox"/> Voiding <input type="checkbox"/> HYSTEROSALPINGOGRAM <input type="checkbox"/> OTHER _____	<input type="checkbox"/> IVP <input type="checkbox"/> with Tomography
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**Mammography & Bone Densitometry**

<input type="checkbox"/> SCREENING <input type="checkbox"/> BONE DENSITOMETRY	<input type="checkbox"/> DIAGNOSTIC <input type="checkbox"/> OTHER	<input type="checkbox"/> UNILATERAL Right / Left <input type="checkbox"/> GALACTOGRAM	<input type="checkbox"/> BREAST BIOPSY (Ultrasound or Stereotactic)
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**Diagnostic Radiology (Specify body part including R, L, Bilateral)**

<input type="checkbox"/> CHEST 1V <input type="checkbox"/> CHEST 2V <input type="checkbox"/> RIBS Right / Left / Bilateral <input type="checkbox"/> NECK Soft Tissues <input type="checkbox"/> SINUS SERIES <input type="checkbox"/> WATER'S VIEW <input type="checkbox"/> ABDOMEN 1V <input type="checkbox"/> ABDOMEN 2V <input type="checkbox"/> OTHER <input type="checkbox"/> C-SPINE LTD. (AP, Lat, Odontoid) <input type="checkbox"/> C-SPINE 5V (AP, Lat, Odontoid, Oblique)	<input type="checkbox"/> T-SPINE <input type="checkbox"/> L-SPINE 3V (AP, Lat) <input type="checkbox"/> L-SPINE 5V (AP, Lat, Oblique) <input type="checkbox"/> SACRUM/COCCYX <input type="checkbox"/> SI JOINTS <input type="checkbox"/> SCOLIOSIS SERIES <input type="checkbox"/> BONE SURVEY <input type="checkbox"/> BONE AGE <input type="checkbox"/> OBSTRUCTIVE SERIES (Chest 2V abdomen)	<input type="checkbox"/> STERNUM <input type="checkbox"/> CLAVICLE Right / Left <input type="checkbox"/> HIP Right / Left <input type="checkbox"/> FEMUR Right / Left <input type="checkbox"/> KNEE Right / Left <input type="checkbox"/> TIBIA/FIBULA Right / Left <input type="checkbox"/> ANKLE Right / Left <input type="checkbox"/> FOOT Right / Left <input type="checkbox"/> OS CALCIS Right / Left <input type="checkbox"/> TOES Right / Left <input type="checkbox"/> SKULL	<input type="checkbox"/> ORBITS <input type="checkbox"/> FACIAL BONES <input type="checkbox"/> NASAL BONES <input type="checkbox"/> MANDIBLE <input type="checkbox"/> SHOULDER Right / Left <input type="checkbox"/> HUMERUS Right / Left <input type="checkbox"/> ELBOW Right / Left <input type="checkbox"/> FOREARM Right / Left <input type="checkbox"/> WRIST Right / Left <input type="checkbox"/> HAND Right / Left <input type="checkbox"/> FINGERS Right / Left
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**Nuclear Medicine (North Fulton Regional Hospital ONLY)**

<input type="checkbox"/> BONE SCAN <input type="checkbox"/> SPECT <input type="checkbox"/> Three Phase Area of interest: _____	<input type="checkbox"/> HEPATOBIILIARY (HIDA) <input type="checkbox"/> LUNG Ventilation/Perfusion <input type="checkbox"/> RENAL SCAN (DTPA) <input type="checkbox"/> with captopril	<input type="checkbox"/> WBC SCAN <input type="checkbox"/> GALLIUM SCAN <input type="checkbox"/> INDIUM SCAN <input type="checkbox"/> THYROID SCAN & UPTAKE	<input type="checkbox"/> OTHER _____
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**Interventional Radiology (North Fulton Regional Hospital ONLY) Specify or speak to radiologist 751-2530**

<input type="checkbox"/> MYELOGRAM (with CT) <input type="checkbox"/> OTHER	<input type="checkbox"/> ARTERIOGRAM	<input type="checkbox"/> ARTHROGRAM	<input type="checkbox"/> IMAGING-GUIDED BIOPSY <input type="checkbox"/> DIALYSIS CATHETER MGMT
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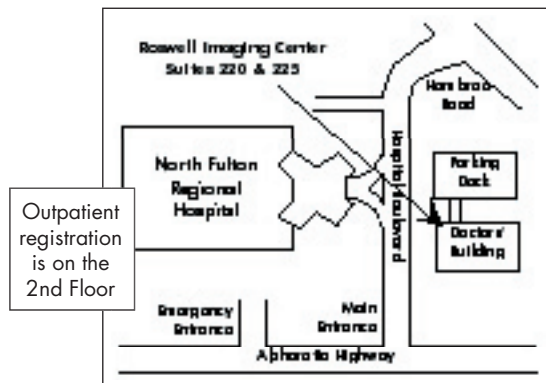
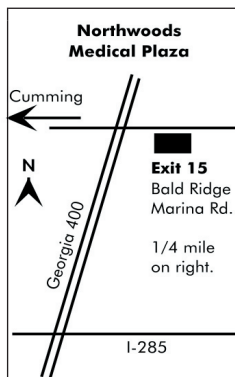
**Patient: Important Information is on the back of this form.**

0342XR124

Physician Signature \_\_\_\_\_

Date \_\_\_\_\_

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## Instructions

- Be sure to follow instructions for your exam preparation. Please bring the following items with you to your appointment:
  - Insurance card
  - Physician's order (prescription)
  - Prior imaging/x-ray/mammogram examination
  - Referral forms from insurance company
- Please be sure any precertification requirements of your healthplan are met prior to your appointment.
- Please arrive at least 30 minutes prior to your appointment.
- Exam results will be sent to your physician within 48 hours.
- If you need to check out your x-rays, please call us 24 hours in advance.
- If you have any questions about preparation or your exam, please contact us at the appropriate number above.

## Exam Preparations

- **ESOPHOGRAM/BARIUM SWALLOW:** No preparation required. (IF THIS IS YOUR ONLY EXAM)
- **UPPER GI:** Do NOT eat or drink anything after midnight or for at least six hours prior to the exam.
- **BARIUM ENEMA:** Pick up "X-Prep Kit #1" from our office. Follow instructions. REQUIRES 24 HOURS.
- **\*\* IVP:** Pick up "X-Prep Kit #1" from our office. Follow instructions. REQUIRES 24 HOURS.
- **ABDOMEN/GALLBLADDER/KIDNEY/AORTA ULTRASOUND:** Do NOT eat or drink anything after midnight or for at least six hours prior to the exam.
- **PELVIC/OB ULTRASOUND:** Drink four 8oz. glasses of liquid one hour prior to appointment. Do NOT empty bladder. Bladder must be full for exam.
- **MAMMOGRAM:** Do NOT use deodorant, powder, or perfume prior to exam.
- **MRI:** Assure that you do NOT have a pacemaker or brain aneurysm clip. Notify staff if you have any metal anywhere in your body.
- **\*\* CT ABDOMEN and/or PELVIS:** Pick up oral contrast bottles from our office. Drink one bottle 4 HOURS PRIOR to the exam, and another 1 HOUR PRIOR to the exam. Except for contrast, do NOT eat or drink anything after midnight, or for at least four hours prior to the exam.
- **\*\* ANY CT EXAM REQUIRING I.V. CONTRAST:** Except for oral contrast, do NOT eat or drink anything after midnight, or for at least four hours prior to the exam.

**\*\* If you are allergic to iodine or IVP DYE, notify our office PRIOR to your appointment.**

**\*\* If you are DIABETIC, you must NOT take GLUCOPHAGE for 48 HOURS AFTER YOUR EXAM.**