

3449 Wilkens Ave., Suite 102, Baltimore, MD 21229-5299 410.368.8675 phone 410.368.8688 fax www.stagnes.org

Patient Name: \_\_\_\_\_

Appointment Date & Time: \_\_\_\_\_

Ordering Physician: \_\_\_\_\_ Date: \_\_\_\_\_

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

Clinical Reason for Exam (required): \_\_\_\_\_

Fax Report: \_\_\_\_\_  Call STAT Report: \_\_\_\_\_

MRI/MRA	CT	ULTRASOUND	BREAST IMAGING
<input type="checkbox"/> No Contrast <input type="checkbox"/> Contrast <input type="checkbox"/> Brain <input type="checkbox"/> IAC <input type="checkbox"/> Pituitary <input type="checkbox"/> Orbits <input type="checkbox"/> TMJ: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Neck (Soft Tissues) <input type="checkbox"/> MRCP <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Hip: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Shoulder: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Knee: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Ankle: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Extremity: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Other: _____	<input type="checkbox"/> No Contrast <input type="checkbox"/> Contrast <input type="checkbox"/> Brain <input type="checkbox"/> Orbits <input type="checkbox"/> IAC <input type="checkbox"/> Calcium Scoring <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Neck (Soft Tissues) <input type="checkbox"/> Full Sinus <input type="checkbox"/> Limited Sinus <input type="checkbox"/> Extremity: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Other: _____	<input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis/TV, if necessary <input type="checkbox"/> Renal <input type="checkbox"/> Bladder <input type="checkbox"/> Aorta <input type="checkbox"/> Scrotum <input type="checkbox"/> Thyroid <input type="checkbox"/> Hysterosonogram <input type="checkbox"/> OB/TV - 1st Trimester <input type="checkbox"/> OB, 2nd Trimester <input type="checkbox"/> OB, 3rd Trimester <input type="checkbox"/> OB, Ltd - Follow-up <input type="checkbox"/> Other: _____	<p><b><u>DIGITAL MAMMOGRAPHY</u></b></p> <input type="checkbox"/> Bilateral <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Screening- Asymptomatic <input type="checkbox"/> Diagnostic- Symptomatic <input type="checkbox"/> Call Back Ultrasound, if necessary
<p><b><u>MR ANGIOGRAPHY</u></b></p> <input type="checkbox"/> Brain <input type="checkbox"/> Neck <input type="checkbox"/> Aorta/Runoff <input type="checkbox"/> Chest <input type="checkbox"/> Renal <input type="checkbox"/> Abdomen <input type="checkbox"/> Other: _____	<p style="background-color: #f4a460; text-align: center;"><b>PET/CT</b></p> <input type="checkbox"/> Whole Body <input type="checkbox"/> Skull base to mid thigh <input type="checkbox"/> Brain <input type="checkbox"/> Chest	<p style="background-color: #f4a460; text-align: center;"><b>X-RAY</b></p> <input type="checkbox"/> Skull <input type="checkbox"/> Orbits <input type="checkbox"/> Sinuses <input type="checkbox"/> Pelvis <input type="checkbox"/> Abdomen <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Ribs: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Hips: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Chest: <input type="checkbox"/> PA&L <input type="checkbox"/> PA <input type="checkbox"/> Abdomen: <input type="checkbox"/> KUB <input type="checkbox"/> 2V <input type="checkbox"/> Extremity, Upper: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Extremity, Lower: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Other: _____	<p><b><u>ULTRASOUND</u></b></p> <input type="checkbox"/> Bilateral <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Palpable Abnormality <input type="checkbox"/> Mammo Abnormality <input type="checkbox"/> Other: _____
<p><b><u>MR ARTHROGRAPHY</u></b></p> <input type="checkbox"/> Shoulder: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Elbow: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Wrist: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Hip: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Knee: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Ankle: <input type="checkbox"/> Right <input type="checkbox"/> Left	<p style="background-color: #f4a460; text-align: center;"><b>FLUOROSCOPY</b></p> <input type="checkbox"/> BE with Contrast: <input type="checkbox"/> Single <input type="checkbox"/> Double <input type="checkbox"/> Small Bowel <input type="checkbox"/> Esophogram <input type="checkbox"/> Myelogram <input type="checkbox"/> Cervical <input type="checkbox"/> Lumbar <input type="checkbox"/> IVP <input type="checkbox"/> UGI <input type="checkbox"/> Hysterosalpingogram <input type="checkbox"/> Other: _____	<p style="background-color: #f4a460; text-align: center;"><b>DEXA</b></p> <input type="checkbox"/> Bone Density Scan	<p><b><u>MRI</u></b></p> <input type="checkbox"/> Bilateral <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Palpable Abnormality <input type="checkbox"/> Mammo Abnormality <input type="checkbox"/> Other: _____ <input type="checkbox"/> Breast Implants: <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Last Mammogram: _____
<div style="border: 1px solid black; padding: 10px; width: fit-content; margin: 0 auto;"> <p>Pre-Authorization Assistance Available.</p> <p style="text-align: center;">~</p> <p>Thank you for choosing Seton Imaging Center.</p> </div>			

**PLEASE BRING THIS SCRIPT AND YOUR INSURANCE CARD ON THE DAY OF YOUR EXAM.**

All diagnostic x-rays are done on a walk-in basis.



**SETON IMAGING  
CENTER**

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### AFTER THE EXAM

Your examination will be read by a board-certified, licensed physician with specialty training in radiology. The results of your tests will be sent directly to your referring doctor and your doctor will inform you of the results.

### BILLING INFORMATION

If you have insurance coverage, we will submit a claim to your insurance company on your behalf. If you are a member of an HMO or managed care plan, please bring your referral form. You will be responsible for any outstanding or unpaid balance. If you have any questions, please contact our billing department at 410.368.8891. If insurance requires co-payment, please provide at the time of service.



 Seton Imaging Center

### PREPARATION INSTRUCTIONS

*If you have questions regarding any of the preparations related to your procedure, please feel free to call us at 410.368.8675. Study times vary in length.*

- MRI** - Please inform us of any metal in your body at the time of scheduling. Please remove any metal, jewelry, or hair pins prior to exam. Specific preparation information will be given when your appointment is scheduled.
- CT** - Abdomen or Pelvis: please pick up the oral contrast and further instructions from your physician or our imaging center.
- P.E.T.** - Allow three hours for exam. Nothing by mouth eight hours prior to exam.
- ULTRASOUND, PELVIS and BLADDER** - Drink 32 ounces of fluid one hour before the exam to fill your bladder. Do not empty your bladder until the exam is complete.
- ULTRASOUND, OB** - Up to 25 weeks gestation, drink 16 ounces of water one hour prior to exam. Do not empty your bladder until the exam is complete. At 28 weeks gestation or greater, no prep.
- DIGITAL MAMMOGRAPHY** - Please do not use any powder, talc, spray or deodorant on breast or underarm area. Wear a two-piece outfit. Please try to obtain your previous mammogram films and reports. Bring them with you at the time of your appointment.
- DEXA** - No calcium supplements 24 hours prior to scheduled scan. No contrast or barium 7 days prior to scheduled scan.
- G.I AND/OR SMALL BOWEL SERIES** - Nothing to eat or drink and no gum chewing after 10 p.m. the evening before the exam.
- BARIUM ENEMA OR AIR CONTRAST ENEMA** - Call scheduling for bowel preparation instructions.
- IVP** - Light supper the day before the exam. Adults take two Dulcolax tablets at 6 p.m. the night before the exam. No solids after supper. No restrictions on liquid intake. Juice, coffee, tea or milk for breakfast the day of the exam. Children under 12, call the office for instructions. Take medications as prescribed.

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\* Children may not accompany patients into procedures. If it is necessary to bring children to the appointment, for your safety, please bring adult supervision to monitor your child.