



Patient's name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone - primary: \_\_\_\_\_ Phone - secondary: \_\_\_\_\_ Insurance: \_\_\_\_\_

Appointment date: \_\_\_\_\_ Appointment time: \_\_\_\_\_ Authorization: \_\_\_\_\_

Call patient to schedule

**Please call when scheduling all STAT exams**

MRI	CT	ULTRASOUND	X-RAY
<p><b>CONTRAST</b></p> <input type="radio"/> Radiologist Discretion <input type="radio"/> W/ <input type="radio"/> W/O <input type="radio"/> W/ & W/O	<p><b>CONTRAST</b></p> <input type="radio"/> Radiologist Discretion <input type="radio"/> W/ <input type="radio"/> W/O	<input type="radio"/> Thyroid <input type="radio"/> Aorta <input type="radio"/> Abdomen Complete <input type="radio"/> Right Upper Quadrant (Liver, Gallbladder, Rt. Kidney, Pancreas) <input type="radio"/> Left Upper Quadrant (Spleen, Lt. Kidney) <input type="radio"/> Liver Only <input type="radio"/> Renal (Kidneys & Bladder) <input type="radio"/> Pelvis (Female Only) <input type="radio"/> OB (Transvaginal As Indicated) <input type="radio"/> Scrotum <input type="radio"/> Soft Tissue Extremity <input type="checkbox"/> Location: _____ <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="radio"/> Soft Tissue Neck <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Anterior <input type="checkbox"/> Posterior <input type="radio"/> Soft Tissue Other Location: _____ <input type="radio"/> Renal Artery <input type="radio"/> Carotid IMT <input type="radio"/> Arterial Scan <input type="radio"/> Thyroid Biopsy <input type="radio"/> Vertebrales <input type="radio"/> Other: _____	<p><b>Please specify:</b></p> <input type="radio"/> Abdomen <input type="radio"/> Pelvis <input type="radio"/> Sinuses <input type="radio"/> Facial Bones <input type="radio"/> Skull <input type="radio"/> Soft Tissue Neck <input type="radio"/> Chest <input type="radio"/> Scoliosis Survey <input type="radio"/> Skeletal Survey <input type="radio"/> Cervical Spine <input type="checkbox"/> Flex. <input type="checkbox"/> Ext. <input type="checkbox"/> Stand <input type="radio"/> Lumbar Spine <input type="checkbox"/> Flex. <input type="checkbox"/> Ext. <input type="checkbox"/> Stand <input type="radio"/> Thoracic Spine <input type="radio"/> Extremity Non-Joint R L B <input type="radio"/> Specify: _____ <input type="radio"/> Extremity Joint: R L B <input type="radio"/> Specify: _____ <input type="radio"/> Other: _____
<input type="radio"/> Brain <input type="checkbox"/> IAC W/ & W/O <input type="checkbox"/> Pituitary <input type="checkbox"/> Orbits W/ & W/O <input type="checkbox"/> Seizure Protocol <input type="radio"/> TMJ <input type="radio"/> Soft Tissue Neck <input type="radio"/> Stroke Protocol (Brain, MRA Head, MRA Neck) <input type="radio"/> Cervical Spine <input type="radio"/> Lumbar Spine <input type="radio"/> Thoracic Spine <input type="radio"/> MRA of: _____ <input type="radio"/> Abdomen <input type="radio"/> Pelvis <input type="radio"/> MRCP <input type="radio"/> Shoulder Rt Lt Bilat <input type="radio"/> Breast Rt Lt Bilat <input type="radio"/> Elbow Rt Lt Bilat <input type="radio"/> Wrist Rt Lt Bilat <input type="radio"/> Hand Rt Lt Bilat <input type="radio"/> Hip Rt Lt Bilat <input type="radio"/> Knee Rt Lt Bilat <input type="radio"/> Ankle Rt Lt Bilat <input type="checkbox"/> Hindfoot <input type="radio"/> Foot Rt Lt Bilat <input type="checkbox"/> Midfoot <input type="checkbox"/> Forefoot <input type="radio"/> MR Arthrogram Rt Lt <input type="radio"/> Other: _____	<input type="radio"/> Head <input type="radio"/> Orbits <input type="radio"/> Paranasal Sinus <input type="radio"/> Paranasal Sinus Stereotactic <input type="checkbox"/> Stealth/Brain Lab <input type="checkbox"/> Fusion <input type="radio"/> Temporal Bones/IAC <input type="radio"/> Facial Bones <input type="radio"/> Soft Tissue Neck <input type="radio"/> Cervical Spine <input type="radio"/> Lumbar Spine <input type="radio"/> Thoracic Spine <input type="radio"/> Chest <input type="radio"/> Cardiac Score <input type="radio"/> Abdomen & Pelvis <input type="checkbox"/> Stone Protocol <input type="radio"/> Abdomen (Only) <input type="radio"/> Pelvis (Only) <input type="radio"/> CTA (All W/ & W/O) <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Head <input type="checkbox"/> Chest/PE Chest <input type="checkbox"/> Neck <input type="checkbox"/> Abdomen & Pelvis <input type="checkbox"/> LE Run-off <input type="radio"/> Dedicated Studies (All W/ & W/O) <input type="checkbox"/> Adrenal <input type="checkbox"/> Pancreas <input type="checkbox"/> Liver <input type="checkbox"/> Renal <input type="radio"/> Other: _____	<p><b>Vascular</b></p> <input type="radio"/> Carotid Doppler <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Bilat <input type="radio"/> Upper Extremity Venous Doppler <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Bilat <input type="radio"/> Lower Extremity Venous Doppler <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Bilat	<p><b>COMMENTS</b></p> <hr/> <p><b>REPORT DELIVERY</b></p> <input type="radio"/> STAT Fax Fax#: _____ <input type="radio"/> Call Report Cell or backline #: _____ <p><b>Standard Report in 24-48 hours.</b></p> <p><b>COMPARISON STUDIES</b></p> Date of service: _____ Location: _____ Type of study: _____
<p><b>MAMMOGRAPHY</b></p> <input type="radio"/> Screening 2D or 3D <input type="radio"/> Diagnostic (breast US as indicated) <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="radio"/> Breast Ultrasound <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="radio"/> Biopsy - Image guided w/post clip <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="radio"/> Needle localization <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="radio"/> Other: _____	<p><b>FLUOROSCOPY</b></p> <input type="radio"/> Barium Enema <input type="radio"/> Air Contrast Barium Enema IVP* <input type="radio"/> Barium Swallow <input type="radio"/> Myelogram <input type="checkbox"/> Cervical <input type="checkbox"/> Lumbar <input type="radio"/> Arthrogram: _____ <input type="radio"/> Upper GI <input type="radio"/> Small Bowel	<p><b>BONE DENSITY</b></p> <input type="radio"/> Bone Density Study	<p><b>IMPLANT</b></p> <input type="radio"/> Pacemaker (no MRI) <input type="radio"/> Neurostimulator <input type="radio"/> Other: Brand: _____ Serial #: _____
<p><b>IMAGE DELIVERY</b></p> <input type="radio"/> Send CD with patient <input type="radio"/> Courier to office			

Insurance (Please fax front and back of patient's card and any clinical information to 864.231.6738)

Clinical indications/Signs/Symptoms: \_\_\_\_\_

ICD-10 Code(s): \_\_\_\_\_

Provider name (printed): \_\_\_\_\_ Provider signature: \_\_\_\_\_

Office phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTE: CAREFULLY FOLLOW EXAM PREPARATION INSTRUCTIONS ON THE BACK SIDE OF THIS FORM**

## PATIENT INSTRUCTIONS

BRING THIS ORDER WITH YOU TO YOUR SCHEDULED EXAM

VISIT US ONLINE AT [WWW.SCDIAG.COM](http://WWW.SCDIAG.COM) FOR DRIVING DIRECTIONS AND TO LEARN MORE ABOUT OUR IMAGING FACILITY AND SERVICES.

## OUR LOCATION

### Directions

**From Easley/Pickens:** Take Route 8 South to I-85 South. Follow Greenville directions from I-85.

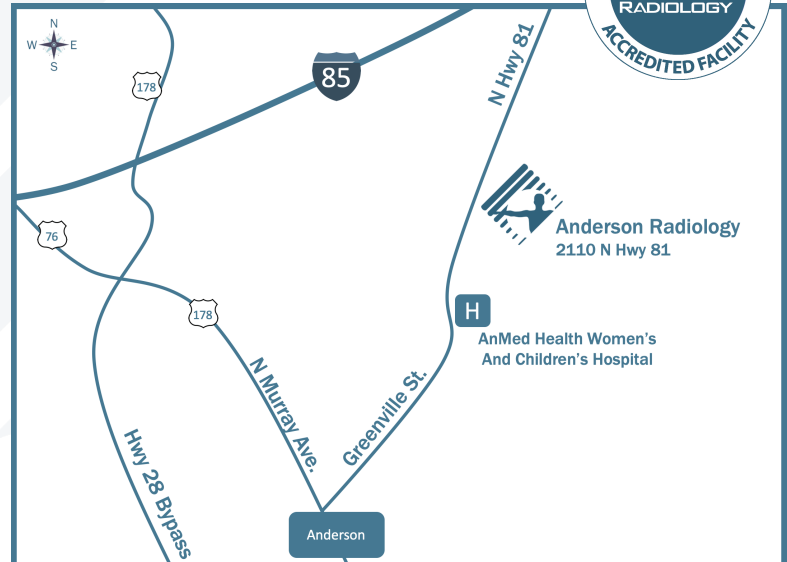
**From Greenville:** Take I-85 South to Route 81. We are located on the left after Hanna High School.

**From Honea Path/Belton:** Take Route 76/178 West to North Main Street in Anderson, take a right on North Main street and go to Greenville Street (81 North). We are located on the right after Clarendon Subdivision.

**From Clemson:** Take Route 28 to Anderson, which turns into Clemson Boulevard/North Main Street (Route 81 N). Continue out 81 and we are located on the right after Clarendon Subdivision.



Anderson Radiology  
2110 Highway 81  
Anderson, SC 29621



## PATIENT INSTRUCTIONS - PREPARING FOR YOUR EXAM

### MRI (Magnetic Resonance Imaging)

**Contrasted Studies:** – 6 hours NPO, may drink decaffeinated drinks, limit salt intake.

### Ultrasound

**Abdomen & Gallbladder** - Nothing by mouth 4 - 6 hours prior to exam. No smoking or chewing gum 4 - 6 hours prior to exam.

**Kidneys** - Full bladder needed. 24 - 36 oz. water ½ to 1 hour prior to exam. DO NOT URINATE.

**Aorta** - Nothing by mouth 8 hours prior to exam.

**Pelvis** - 32 oz. water ½ to 1 hour prior to exam. DO NOT URINATE.

**Thyroid** - No prep.

**Carotid Artery** - No prep.

**Testicle** - No prep.

**Venous Doppler** - No prep.

**Breast** - No prep.

**OB - 1st and 2nd Trimester** - same as Pelvis (above).

**OB - 3rd Trimester** - 16 oz. water ½ to 1 hour before exam. Hold bladder full.

**Arterial Doppler** - No prep.

### Mammography

Please wear a two-piece outfit. Wear no powders, perfumes, or deodorants around the breast area. Please bring previous Mammography films that were not performed at Anderson Radiology.

### X-ray / Fluoroscopy

**Barium Swallow** - 4 hours NPO.

**Upper GI** - Nothing by mouth after midnight.

**Small Bowel** - Nothing by mouth after midnight.

**Barium Enema** - Special 24 hour prep. Call Anderson Radiology.

**IVP** - Special 24 hour prep. Call Anderson Radiology. May drink fluids.

### CT (Computed Tomography)

Any CT with I.V. Contrast no food 4 hours prior-may drink fluids.

**Chest** - No food 2 hours prior, bring recent Chest X-rays for correlation and planning.

**Abdomen** - No food 4 hours prior - may drink water.

**Pelvis** - No food 4 hours prior - may drink water.

**All other CT Exams** - No prep unless receiving I.V. Contrast, then nothing by mouth 4 hours prior to exam.

**Cardiac Score** - No caffeine or vigorous activity 4 hours before.

**\*BUN and Creatinine levels are required before IV Contrast for patients over age 60, unless indicated.**



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[www.SCDiag.com](http://www.SCDiag.com)