



WWW.WNYIG.COM

- STAT Report
  - Send CD with Patient
  - Send Films with Patient
- Exam Date \_\_\_\_\_  
Exam Time \_\_\_\_\_

Today's Date: \_\_\_\_\_

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

Patient Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Type of Ins.: \_\_\_\_\_ Auth#: \_\_\_\_\_

Reason for Exam: \_\_\_\_\_

Physician's Signature \_\_\_\_\_

LAB

Onsite lab screening, as recommended by ACR Screening Guidelines for Contrast Exams.

- BUN, creatinine and GFR
- Over the age of 60
- Renal disease
- History of hypertension
- Diabetic

**HIGH FIELD MRI**

WNY MRI  KEN-TON  LOCKPORT  PARK CLUB LANE

with contrast  without

- Brain
  - Orbits
  - TMJ  L  R
  - Soft Tissue Neck
  - IAC
  - Pituitary (Sella Turcica)
  - Cervical Spine ( Flex  Ext)
  - Thoracic Spine
  - Lumbar Spine ( Weight Bearing)
  - Pelvis
  - Shoulder  L  R
  - Elbow  L  R
  - Wrist  L  R
  - Hand  L  R
  - Hip  L  R
  - Knee  L  R
  - Ankle  L  R
  - Foot  L  R
  - Other \_\_\_\_\_
- Chest
  - Breast MRI \*\*
  - Arthrogram \*\*\*
  - Adrenal
  - Abdomen
  - Liver  Eovist
  - Kidneys
  - Pancreas
  - MRCP
  - MRA or  MRV
  - Carotids  Brain
  - Upper Ext
  - Lower Ext
  - Chest
  - Abdomen  Renal
  - Pelvis
  - Peripheral Runoff

\*\* Exam Performed at WNY MRI & LOCKPORT MRI & PARK CLUB LANE ONLY  
 \*\*\* Exam Performed at WNY MRI ONLY

**COMPUTERIZED TOMOGRAPHY**

WNY MRI  KEN-TON  PARK CLUB LANE

- Brain  with contrast  without
- Orbits
- Temporal Bones
- Sinuses
- Soft Tissue Neck
- Chest
- Abdomen
- Pelvis
- Spine (specify)  Cervical  Thoracic  Lumbar
- CT Angiography (specify) \_\_\_\_\_
- Other \_\_\_\_\_

**Note:**  
 For PET/CT,  
 64 Slice Diagnostic CT  
 Please See Reverse  
 Side Of This Form

**GENERAL X-RAY**

ALDEN  BROADWAY  HAMBURG  NIAGARA ST.  
 WNY MRI  KEN-TON  LOCKPORT  
 PARK CLUB LANE  PARISH COMMONS

- C Spine  Comp  AP/LAT  FLX/EXT  Hip  L  R
- L Spine  Comp  AP/LAT  FLX/EXT  Femur  L  R
- T Spine  Knee  L  R
- Chest  PA  Lat.  Tibia/Fib  L  R
- Sacrum/Coccyx  Ankle  L  R
- Abdomen  KUB  Complete  Foot  L  R
- Pelvis  Shoulder  L  R
- Ribs  L  R  Humerus  L  R
- Sinuses  Elbow  L  R
- Skull  Forearm  L  R
- Orbits  Wrist  L  R
- Other \_\_\_\_\_  Hand  L  R
- Scoliosis (Available at KEN-TON Only)  Finger  L  R
- Lateral Neck (Adenoids)
- Bone Age

**FLUOROSCOPY**

KEN-TON  PARK CLUB LANE

- Esophogram  Small Bowel Series
- UGI Series  Modified Barium Swallow  
(No Speech Pathologist)
- UGI & SBFT
- Therapeutic Joint Injections

**MAMMOGRAPHY**

PARK CLUB LANE  WNY MRI  LOCKPORT

- L  R
- Screening Mammogram (with 3D tomosynthesis or ultrasound if needed)
- Diagnostic Mammogram (with 3D tomosynthesis or ultrasound if needed)

**BONE DENSITOMETRY**

PARK CLUB LANE  WNY MRI  NIAGARA ST  LOCKPORT

**ULTRASOUND**

HAMBURG  BROADWAY  LOCKPORT  
 WNY MRI  PARK CLUB LANE  KEN-TON

- Thyroid  Scrotum/Testicular
- Breast  Carotid Doppler
- Fetal  Abdominal Aorta (AAA) specify area
- Abdomen  Venous Doppler Lower Extremity  L  R
- Pelvic  Venous Insufficiency Study
- Transvaginal  Segmental Arterial Doppler With ABI's \*\*
- Renal \*  Other

WNY MRI

Digital Motion X-Ray  Cervical Spine  Other \_\_\_\_\_

WNY MRI  PARK CLUB LANE

- Renal Flow & Scan
- Salivary Gland Imaging
- Other \_\_\_\_\_
- Bone Scan Whole Body
- 3 Phase Bone Scan
- Hepatobiliary Scan with CCK for Gallbladder EF
- Liver-Spleen Scan
- Thyroid Uptake Scan
- MUGA Scan
- \*Instructions and preparations for NM exams will be given at the time of scheduling*

Diagnosis or Clinical Suspicion (required) Rule Out Diagnosis Not Acceptable	<b>Patient Name:</b> _____
History/Clinical Information (required)	<b>Patient Phone:</b> _____ <b>DOB:</b> _____
ICD-10 Codes	<b>Referring Physician:</b> _____
Type of Previous Exam: Date of Exam: Location of Imaging Center:	<b>Type of Ins.:</b> _____ <b>Auth#:</b> _____
Lab Results    BUN _____     Creatinine: _____     Date of Labs: _____	<b>Physician's Signature</b> _____
<b>Cautions/Risks/Contrast Allergy/Potential Pregnancy     PLEASE EXPLAIN:</b>	
Is the Patient Diabetic?    Yes    No     Type of Insulin:    Injected: _____    Oral Agent: _____	

<b>PET/CTEXAM</b> <input type="checkbox"/> Solitary Pulmonary Nodule <input type="checkbox"/> Lung Cancer <input type="checkbox"/> Colorectal Cancer <input type="checkbox"/> Lymphoma <input type="checkbox"/> Melanoma <input type="checkbox"/> Head and Neck Cancer *Please check box below in addition to the type of exam <input type="checkbox"/> Staging <input type="checkbox"/> Restaging <input type="checkbox"/> Monitoring Therapy <input type="checkbox"/> Head - Thighs	<input type="checkbox"/> Esophageal Cancer <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Thyroid Cancer <input type="checkbox"/> Gallium - 68 NetSpot <input type="checkbox"/> Other _____	<b>Brain</b> <input type="checkbox"/> Seizures <input type="checkbox"/> Dementia <input type="checkbox"/> Brain Tumor - Post Surgery
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<b>64 SLICE CT ANGIOGRAPHY</b> <input type="checkbox"/> Circle of Willis (CTA Brain) <input type="checkbox"/> Carotid (CTA Neck) <input type="checkbox"/> Thoracic Aorta (CTA Chest) <input type="checkbox"/> Abdominal Aorta (CTA ABD/PEL) <input type="checkbox"/> Total Aorta	<input type="checkbox"/> Abdominal Aorta with Runoff <input type="checkbox"/> Pulmonary Arteries (CT Chest) <input type="checkbox"/> CTA Chest for PE	<input type="checkbox"/> Other _____ _____ _____ _____
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<b>DIAGNOSTIC CT</b> <input type="checkbox"/> <b>with contrast</b> <input type="checkbox"/> <b>w/o contrast</b> <input type="checkbox"/> Head/Brain <input type="checkbox"/> Orbits <input type="checkbox"/> IAC <input type="checkbox"/> Facial Bone <input type="checkbox"/> Sinuses <input type="checkbox"/> Temporal Bones <input type="checkbox"/> Soft Tissue/Neck <input type="checkbox"/> Sternum	<input type="checkbox"/> Chest <input type="checkbox"/> High Res <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Ribs	<input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> Tib/Fib	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> 3D Reconstruction <input type="checkbox"/> Other _____ _____ _____ _____
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**Preparation instructions for CT**

Exams requiring preparation or IV contrast

Chest \* Abdomen \* Pelvis \* Soft Tissue Neck \* Brain  
 (When ordered with contrast)

- 1.) Nothing to eat for (4) four hours prior to exam. If you are diabetic, call to see if medication(s) need to be discontinued and bloodwork.
- 2.) Abdomen and/or Pelvis exams need to drink oral contrast 1-2 hours prior to exam. The drink may be picked up at our office prior to the appointment.

**Preparation instructions for PET**

- \* Beginning two days before your exam please do not exercise and avoid strenuous activities since this will severely interfere with the results of your study. After your exam you will be able to resume normal activities.
- \* No caffeine, alcohol or tobacco 24 hours prior to the exam.
- \* Start a **NO/LOW CARBOHYDRATE** (sugar) diet 24 hours before appointment. This means avoiding bread, pasta, potatoes, rice, candy, fruits and sugars. You can eat eggs, vegetables, meat (chicken, pork, beef).
- \* **DO NOT EAT** for six (6) hours prior to your study. Diabetics should fast for at least two (2) hours prior to the study. You may take your medications with water the day of

your exam. If you need pain medication please remember to bring it with you. You must have a driver with you when using pain medications.

- \* Please drink several glasses of water before arriving for your study.
- \* Please leave all valuables at home. Small lockers are available at WNY MRI for your convenience.
- \* If you require oxygen, please bring your portable device with you and enough oxygen to last for at least 3 hours.
- \* Wear comfortable shoes and clothing. Do not wear jewelry or clothing that contains metal. Gowns will be provided for you if you have to change.
- \* Plan on spending 2 to 3 hours at WNY MRI for your study. This includes the time necessary for the material that was prepared for you to be absorbed by the body. The actual time you spend lying down in the PET/CT unit can vary from 10 to 30 minutes on average depending on what type of study your doctor has ordered.
- \* **Due to the high cost of material for PET exams, if you need to cancel/ reschedule, please call 24 hours Prior to your exam.**

**LOCATIONS**

**WNY MRI**

222 Genesee Street, Buffalo, NY 14203  
**P 716.855.2866 F 716.855.2860**

**WNY MRI WOMEN'S IMAGING AND**

**WNY MRI @ PARK CLUB LANE**

180 Park Club Lane, Suite 150  
 Williamsville, NY 14221  
**P 716.204.0028 F 716.428.3824**

**WNY MRI @ KEN-TON OPEN MRI**

2882 Elmwood Ave., Kenmore, NY 14217  
**P 716.876.7000 F 716.876.7447**

**WNY MRI @ LOCKPORT**

170 Professional Pkwy., Lockport, NY 14094  
**P 716.438.2400 F 716.439.6264**