

Patient Information

Patient Name: _____ DOB: _____
Sex: Male () Female () Home Phone: _____ Work or Cell Phone: _____

★ICD-9: _____ ★Diagnosis: _____

Physician Information

Physician Name: _____ Phone: _____
Contact Person: _____ Fax: _____
★Physician Signature (no stamps): _____ ★Date: ____/____/____

Insurance Information

Primary Insurance Carrier: _____ Phone: _____
Member ID #: _____ Group #: _____ Precertification #: _____
Insured Name: _____ Insured DOB: _____
Secondary Insurance Carrier: _____ Phone: _____
Member ID #: _____ Group #: _____ Precertification #: _____

X-RAY (Weight limit 600 lbs)	X-RAY (Weight limit 600 lbs)	MRI (Weight limit 550 lbs)	MRI (Weight limit 550 lbs)
<input type="checkbox"/> DX Ankle <input type="checkbox"/> Bilat <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> DX Bone Age <input type="checkbox"/> DX Calcaneus <input type="checkbox"/> Bilat <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> DX Cervical Spine <input type="checkbox"/> Obliques <input type="checkbox"/> with Flexion/Extension <input type="checkbox"/> Flexion/Extension Only <input type="checkbox"/> DX Chest 1 view (Posterior) <input type="checkbox"/> DX Chest 2 view (Posterior & Lateral) <input type="checkbox"/> DX Clavicle <input type="checkbox"/> Bilat <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> DX Elbow <input type="checkbox"/> Bilat <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> DX Facial Bones <input type="checkbox"/> DX Femur <input type="checkbox"/> Bilat <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> DX Fingers <input type="checkbox"/> Bilat <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> DX Foot <input type="checkbox"/> Bilat <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> DX Forearm <input type="checkbox"/> Bilat <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> DX Hand <input type="checkbox"/> Bilat <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> DX Hip <input type="checkbox"/> Bilat <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> DX Humerus <input type="checkbox"/> Bilat <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> DX Knee <input type="checkbox"/> Bilat <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> DX KUB <input type="checkbox"/> DX KUB w/Upright ABD <input type="checkbox"/> DX Lumbar Spine <input type="checkbox"/> Obliques <input type="checkbox"/> with Flexion/Extension <input type="checkbox"/> Flexion/Extension Only <input type="checkbox"/> DX Nasal Bones <input type="checkbox"/> DX Pelvis <input type="checkbox"/> DX Ribs <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> DX Sacrum and Coccyx	<input type="checkbox"/> DX Skeletal Survey <input type="checkbox"/> DX Shoulder <input type="checkbox"/> Bilat <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> DX SI Joints <input type="checkbox"/> DX Sinuses, Complete <input type="checkbox"/> DX Skull <input type="checkbox"/> DX Sternum <input type="checkbox"/> DX Thoracic Spine <input type="checkbox"/> Obliques <input type="checkbox"/> with Flexion/Extension <input type="checkbox"/> Flexion/Extension Only <input type="checkbox"/> DX Tib/Fib <input type="checkbox"/> Bilat <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> DX Toes <input type="checkbox"/> Bilat <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> DX Wrist <input type="checkbox"/> Bilat <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> X-ray Other: _____	<input type="checkbox"/> Without Contrast <input type="checkbox"/> With Contrast <input type="checkbox"/> With and Without Contrast <input type="checkbox"/> MRI Brain <input type="checkbox"/> MRI Brain Functional <input type="checkbox"/> MRI Brain DTI (tractography) <input type="checkbox"/> MRI Brain Perfusion <input type="checkbox"/> MRI Brain Spectroscopy <input type="checkbox"/> MRI MRA Neuro <input type="checkbox"/> Intra Cranial <input type="checkbox"/> Extra Cranial <input type="checkbox"/> MRI Orbit <input type="checkbox"/> MRI Pituitary <input type="checkbox"/> MRI Cranial Nerve <input type="checkbox"/> General <input type="checkbox"/> 5 th Nerve <input type="checkbox"/> MRI CSF Flow <input type="checkbox"/> MRI IAC <input type="checkbox"/> MRI Soft Tissue Neck <input type="checkbox"/> MRI Chest <input type="checkbox"/> MRI MRA Chest <input type="checkbox"/> MRI Cardiac <input type="checkbox"/> MRI Cervical Spine <input type="checkbox"/> MRI Thoracic Spine <input type="checkbox"/> MRI Lumbar Spine <input type="checkbox"/> MRI MRCP <input type="checkbox"/> MRI MRV Body Part: _____ <input type="checkbox"/> MRI Abdomen <input type="checkbox"/> Liver <input type="checkbox"/> Renal Mass <input type="checkbox"/> Pancreas <input type="checkbox"/> MRI MRA Abdomen <input type="checkbox"/> Liver Transplant <input type="checkbox"/> Renal	<input type="checkbox"/> MRI Pelvis <input type="checkbox"/> Whole Pelvis <input type="checkbox"/> Prostate <input type="checkbox"/> Female Pelvis <input type="checkbox"/> MRI Lower Extremity <input type="checkbox"/> R <input type="checkbox"/> L Body Part: _____ <input type="checkbox"/> MRI Upper Extremity <input type="checkbox"/> R <input type="checkbox"/> L Body Part: _____ <input type="checkbox"/> MRI Other: _____
		CT (Weight limit 650 lbs)	
		<input type="checkbox"/> Without Contrast <input type="checkbox"/> With Contrast <input type="checkbox"/> With and Without Contrast <input type="checkbox"/> CT Head <input type="checkbox"/> CT Sinus <input type="checkbox"/> CT Maxillofacial <input type="checkbox"/> CT IAC / Temporal Bones <input type="checkbox"/> CT Soft Tissue Neck <input type="checkbox"/> CT Cervical Spine <input type="checkbox"/> CT Chest <input type="checkbox"/> CT Chest PE Protocol <input type="checkbox"/> CT Thoracic Spine <input type="checkbox"/> CT Lumbar Spine <input type="checkbox"/> CT Abdomen <input type="checkbox"/> CT Pelvis <input type="checkbox"/> CT IVP <input type="checkbox"/> CT Upper Extremity <input type="checkbox"/> R <input type="checkbox"/> L Body Part: _____ <input type="checkbox"/> CT Lower Extremity <input type="checkbox"/> R <input type="checkbox"/> L Body Part: _____ <input type="checkbox"/> CT Angio (CTA): _____ <input type="checkbox"/> CT Other: _____	
		Received Order	
		Date: ____/____/____ Time: ____:____ <input type="radio"/> A.M. <input type="radio"/> P.M.	

Requested Date and Time A.M. P.M. **Scheduled** Arrival A.M. P.M. Appointment A.M. P.M.
Date: ____/____/____ Time: ____:____ Date: ____/____/____ Time: ____:____

Areas marked with a ★ are Required

Legend: Bilat = Bilateral, CT = Computed Tomography, DOB = Date of Birth, ICD-9 = International Certification of Diseases, L = Left, MRI = Magnetic Resonance Imaging, R = Right

BAYLOR UNIVERSITY MEDICAL CENTER
DALLAS, TEXAS



52880 (04/11)

SCHEDULING REQUEST AND ORDER FORM

Test Preparations

X-Ray

UPPER GI AND/OR SMALL BOWEL:

Do not eat, drink, smoke, or chew gum after midnight the night before your exam. If prescription medications are to be taken, it needs to be done 2 hours prior to exam. Diabetic patients should consult their physician for insulin directions.

Barium Enema (BE):

PATIENT PREP:

- Day prior to exam
 - Clear liquids
 - 10 oz Magnesium Citrate at 12:00pm
 - 4 Dulcolax tablets at 4pm
 - Glass of water every hour from 1pm until 10pm
- Day of Exam
 - Use a Dulcolax suppository 3 hours prior to exam
 - No food or drink until study is complete

MRI/MRA

No diet restrictions. Please wear loose clothing with no metal, no jewelry, and no eye make-up. If you have metal implants and/or stents in your body, please call the department for further instructions.

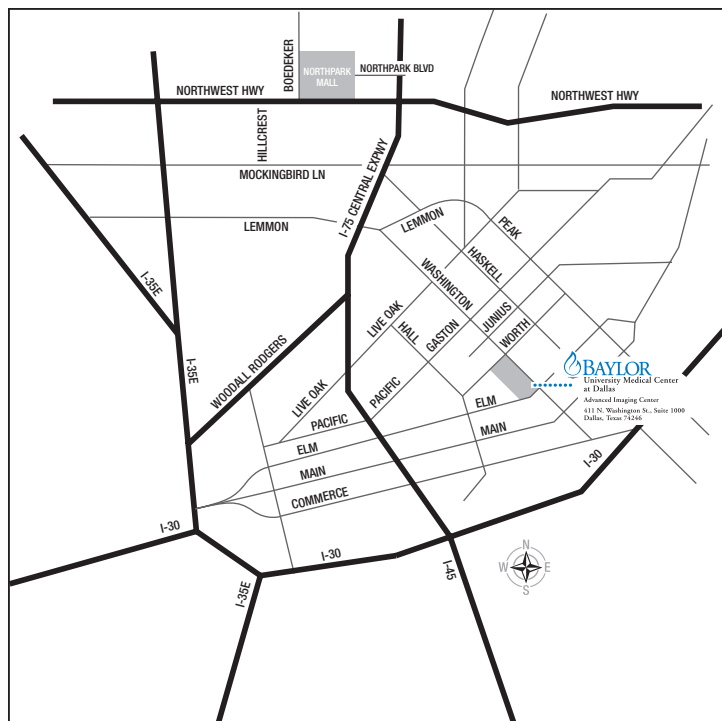
CT Scan

CT SCAN OF THE ABDOMEN and/or PELVIS:

No food or liquid 4 hours prior to appointment. Diabetic patients may take medication with minimal food/liquid.

ALL OTHER CT SCANS:

No preparation required.



Baylor University Medical Center Advanced Imaging Center

Is located within the Tom Landry Building on the Baylor campus.

Address: 411 North Washington Ave., Suite 1000
Dallas, Texas 75246
(214) 820-8770 Phone, (214) 820-8778 Fax

Parking: Valet parking available. Free underground and surface parking at the Tom Landry Center.

Appointments: Monday - Friday. 8 a.m. - 4:00 p.m.

DIRECTIONS TO TOM LANDRY BUILDING;

FROM NORTH DALLAS HWY 75

- South on Hwy 75
- Exit Haskell
- Turn left on Haskell
- Turn right at Worth Street
- Turn left at N. Washington Street

FROM NORTH DALLAS – TOLLWAY

- Take the tollway south through the toll plaza towards downtown
- Take Harwood exit (left) & continue through 9 traffic lights
- Turn left at Pacific Street
- Pacific Street will change into Gaston Ave after you go under Central Expressway
- Turn right at Washington Street

FROM DALLAS I-35

- I-35 to downtown interchange & exit I-30 East
- Exit Carroll, Peak & Haskell
- Turn left onto Peak
- Turn left at Worth Street
- Turn left at Washington Street

FROM SOUTH DALLAS I-45 & I-75

- North on I-45
- Exit Main & Elm
- Turn left at Main Street
- Turn right on Central Expressway to 2nd traffic light
- Turn right on Pacific Street
- Pacific Street turns into Gaston Ave
- Turn right at Washington Street

FROM WEST DALLAS I-30

- I-30 East
- Exit Carroll, Peak & Haskell
- Turn left onto Peak
- Turn left at Worth Street
- Turn left at Washington Street

FROM EAST DALLAS I-30

- I-30 West
- Exit Carroll/Peak
- Turn right onto Peak
- Turn left at Worth Street
- Turn left at Washington Street