



**SILICON VALLEY
MEDICAL IMAGING**
PROVIDING CLARITY

**3-TESLA
MRI**
CT SCANS | X-RAY

2191 Mowry Ave. Suite 500-H
Fremont, California 94538
(Located across the street from Washington Hospital)
TEL: 510.792.9700 | FAX: 510.792.9701
Open Evenings and Saturdays

| PATIENT INFO | | PHYSICIAN INFO | | INSURANCE |
|----------------|-------|----------------|-------------|-----------|
| PT. NAME: LAST | FIRST | MD. NAME: | MD. SIGN: | |
| PT. DOB: | | MD. TEL: | ORDER DATE: | |
| PT. TEL: | | MD. FAX: | INDICATION: | |

| MRI & MRA (3-TESLA) | CT SCANS | X-RAY |
|---|--|---|
| CONTRAST* <input type="checkbox"/> With <input type="checkbox"/> W/out <input type="checkbox"/> Both <small>Patients > 60yrs need BUN, Creatinine, GFR</small> | CONTRAST* <input type="checkbox"/> With <input type="checkbox"/> W/out <input type="checkbox"/> Both <small>Patients > 60yrs need BUN, Creatinine, GFR</small> | <input type="checkbox"/> Chest <small>Please select views</small> <input type="checkbox"/> Neck <small><input type="checkbox"/> AP <input type="checkbox"/> Lat <input type="checkbox"/> Both</small> <input type="checkbox"/> Hip <small>Please select side</small> <input type="checkbox"/> Head <small><input type="checkbox"/> LT <input type="checkbox"/> RT <input type="checkbox"/> Both</small> <input type="checkbox"/> Knee <input type="checkbox"/> Abdo/KUB <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Shoulder <input type="checkbox"/> Pelvis <input type="checkbox"/> Other _____ |
| 1. NEURO / ENT <input type="checkbox"/> MRI Brain <input type="checkbox"/> MRA Brain <input type="checkbox"/> MRA Neck/Carotid <div style="border: 1px solid black; padding: 2px; margin: 5px 0;"><input type="checkbox"/> TIA/Stroke protocol Includes all 3 above</div> <input type="checkbox"/> Pituitary <input type="checkbox"/> MRI Orbits/Face <input type="checkbox"/> MRI Neck <input type="checkbox"/> IAC's CONTRAST <input type="checkbox"/> With <input type="checkbox"/> W/out <input type="checkbox"/> Both | 5. MRA <input type="checkbox"/> MRA Brain <input type="checkbox"/> MRV Brain <input type="checkbox"/> MRA Neck/Carotid Arteries <input type="checkbox"/> MRA Abdominal Aorta <input type="checkbox"/> MRA Renal Arteries <input type="checkbox"/> MRA Pelvis <input type="checkbox"/> MRV Pelvis <input type="checkbox"/> MRA Run-off <input type="checkbox"/> MRA Lower Extremities <input type="checkbox"/> MRA Abdomen & Pelvis <input type="checkbox"/> Other _____ | <input type="checkbox"/> Head <small>Please select side</small> <input type="checkbox"/> Shoulder <small><input type="checkbox"/> LT <input type="checkbox"/> RT <input type="checkbox"/> Both</small> <input type="checkbox"/> Liver 3-Phase <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Sinus <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Neck <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Knee <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Hip <input type="checkbox"/> CTA Run-off <input type="checkbox"/> Pelvis <input type="checkbox"/> CTA Lower Extremities <input type="checkbox"/> CTA Abdomen & Pelvis <input type="checkbox"/> High Resolution CT <input type="checkbox"/> Other _____ |

2. SPINE

Cervical Spine
 Thoracic Spine
 Lumbar Spine

CONTRAST
 With W/out Both

3. BODY Please select side

Pelvis LT RT Both

Abdomen
 Biliary (MRCP)
 Brachial Plexus
 Breast
 Chest/Mediastinum
 Enterography

CONTRAST
 With W/out Both

4. JOINTS Please select side

Hand/Wrist LT RT Both

Elbow
 Shoulder
 Knee
 Foot/Ankle
 Other _____

CHECKLIST FOR PATIENTS

- Bring your ID and Health Insurance Cards
 - Wear warm and comfortable clothing
 - Arrive 15 minutes before your appointment
 - Bring all your medications with you
- NOTE:** PLEASE NOTIFY US BEFOREHAND for special accomodations such as accompanying children, transportation assistance, time constraints, upcoming doctor's appointment, **wheelchair**, prior stroke or **difficult venous access**.

- INFORM US IF YOU HAVE A PACEMAKER, HEART VALVE, ANEURYSM CLIP OR COCHLEAR IMPLANT. OR HAD BRAIN, HEART, EYE, OR EAR SURGERY OR IF YOU HAVE ANY METALLIC OBJECTS /IMPLANTS.**
- If you have a history of kidney disease or kidney failure and your exam is scheduled with contrast, please notify us so we can determine whether contrast should be used or not.
 - In preparation for your MRI you may be asked to remove make-up and dentures depending on the study. You may also be asked to wear a hospital gown to avoid magnetic interference from buckles, zippers etc.
 - Once you are situated on the table, make sure you are comfortable so that it easy to keep still. Breath normally. There is nothing about the procedure that should make you uncomfortable. Once the exam is over, the Technologist will assist you out of the scan room.
 - Fluids in moderation are encouraged before the exam.
 - Continue to take medication prescribed by your doctor as directed.

DRIVING DIRECTIONS
From Oakland - Take I-880 Southbound, take the Mowry Ave exit. Make left at Mowry Ave. Go about 3 miles. Facility on your Left.
From San Jose - Take I-880 Northbound, take the Mowry Ave exit. Right at Mowry Ave. Go about 3 miles. Facility on your Left.

NOTES: * Please Include recent BUN/Creatinine levels for contrast order

NOTES

24 Hr Cancellation Required