

MINK RADIOLOGIC IMAGING

APPOINTMENT DATE: _____ TIME: _____

NAME: _____ D.O.B.: _____

REFERRING PHYSICIAN: _____

CLINICAL INDICATION: _____

ADDITIONAL REPORTS TO: _____

BEVERLY HILLS

Main Tel: 310.358.2100

Scheduling Fax: 310.358.2131

MARINA DEL REY

Main Tel: 310.305.4500

Scheduling Fax: 310.305.4611

WESTWOOD (Open MR Only)

Main Tel: 310.208.3100

Scheduling Fax: 310.208.3101

www.minkrad.com

<input type="checkbox"/> MRI	<input type="checkbox"/> OPEN MRI	<input type="checkbox"/> CT w/3D REFORMS	<input type="checkbox"/> XRAY	<input type="checkbox"/> U/S
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SKELETAL <input type="checkbox"/> R <input type="checkbox"/> L	SPINE	PAIN MANAGEMENT	U/S EXAMINATION
<input type="checkbox"/> SHOULDER <input type="checkbox"/> ELBOW <input type="checkbox"/> WRIST <input type="checkbox"/> HAND <input type="checkbox"/> HIP/PELVIS <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> WITH IV CONTRAST Creatinine _____ <input type="checkbox"/> MR ARTHROGRAM Creatinine not needed	<input type="checkbox"/> CERVICAL <input type="checkbox"/> THORACIC <input type="checkbox"/> LUMBAR <input type="checkbox"/> SACRUM/SI JOINTS <input type="checkbox"/> BRACHIAL PLEXUS <input type="checkbox"/> WITH IV CONTRAST Creatinine _____	<input type="checkbox"/> EPIDURAL <input type="checkbox"/> TRANSLAMINAR <input type="checkbox"/> TRANSFORAMINAL <input type="checkbox"/> CAUDAL <input type="checkbox"/> FACET BLOCKS LEVELS _____ <hr/> MYELOGRAPHY <input type="checkbox"/> CERVICAL <input type="checkbox"/> THORACIC <input type="checkbox"/> LUMBAR <hr/> ANGIOGRAPHY <input type="checkbox"/> CIRCLE OF WILLIS <input type="checkbox"/> NECK/CAROTID <input type="checkbox"/> AORTA/RENALS <input type="checkbox"/> LOWER EXTREMITY <input type="checkbox"/> UPPER EXTREMITY <input type="checkbox"/> WITH IV CONTRAST Creatinine _____	<input type="checkbox"/> ABDOMEN <input type="checkbox"/> RT UPPER QUAD <input type="checkbox"/> RENAL <input type="checkbox"/> BLADDER <input type="checkbox"/> AORTA <input type="checkbox"/> PROSTATE <input type="checkbox"/> SCROTUM <input type="checkbox"/> THYROID <input type="checkbox"/> PELVIS <input type="checkbox"/> SONOHYSTEROGRAM <input type="checkbox"/> OTHER _____
BODY	HEAD AND NECK		SPECIAL INSTRUCTIONS
<input type="checkbox"/> CHEST <input type="checkbox"/> ABDOMEN <input type="checkbox"/> PELVIS <input type="checkbox"/> MRCP <input type="checkbox"/> ENTEROGRAPHY <input type="checkbox"/> WITH IV CONTRAST Creatinine _____	<input type="checkbox"/> BRAIN <input type="checkbox"/> PITUITARY <input type="checkbox"/> ORBITS <input type="checkbox"/> IAC <input type="checkbox"/> TEMPORAL BONE <input type="checkbox"/> NECK <input type="checkbox"/> SINUS <input type="checkbox"/> INSTATRAX SINUS <input type="checkbox"/> WITH IV CONTRAST Creatinine _____		<div style="border: 1px solid black; height: 150px; width: 100%;"></div>

BEVERLY HILLS

High Field MRI; CT; U/S; Xray
8670 Wilshire Boulevard, Suite 101
Beverly Hills, CA 90211
Main Tel: 310.358.2100

MARINA DEL REY

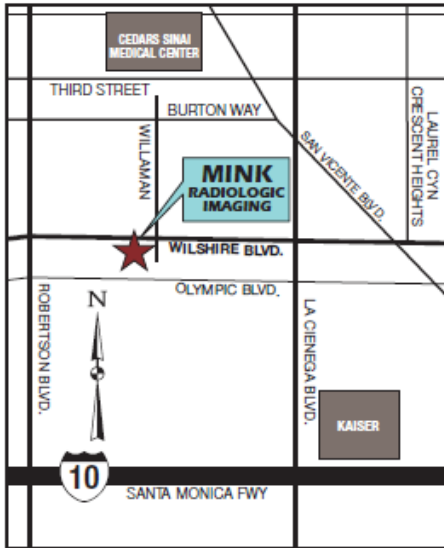
High Field MRI; CT; Xray
13160 Mindanao Way, Suite 175
Marina del Rey, CA 90292
Main Tel: 310.305.4500

WESTWOOD

Open MRI Only
10921 Wilshire Blvd., Mezzanine
Los Angeles, CA 90024
Main Tel: 310.208.3100

COMPLIMENTARY PARKING IS PROVIDED AT ALL LOCATIONS.

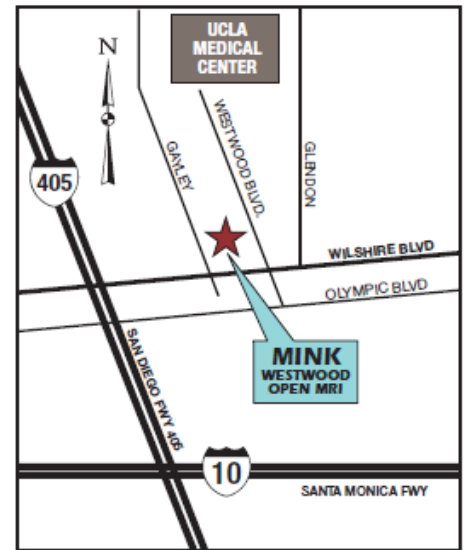
BEVERLY HILLS
ENTER ON WILLAMAN



MARINA DEL REY
ENTER ON MINDANAO WAY OR GLENCOE



WESTWOOD
ENTER ON GAYLEY



PLEASE BRING THIS REQUISITION AND INSURANCE INFORMATION WITH YOU AT THE TIME OF YOUR EXAMINATION AND ARRIVE 15 MINUTES BEFORE APPOINTMENT TO REGISTER