


**REPORTING INSTRUCTIONS**

- Stat Call Report to PH # \_\_\_\_\_
- Stat Fax Report to FX # \_\_\_\_\_
- Patient to Return:  with Films  with CD

|                                                                              |                                       |                                                                       |
|------------------------------------------------------------------------------|---------------------------------------|-----------------------------------------------------------------------|
| <input type="checkbox"/> PATIENT WILL CALL                                   | <input type="checkbox"/> CALL PATIENT | TODAY'S DATE                                                          |
| PATIENT'S LAST NAME                                                          | FIRST                                 | M                                                                     |
| GENDER<br><input type="checkbox"/> MALE <input type="checkbox"/> FEMALE      |                                       | PREGNANT?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| PATIENT'S DATE OF BIRTH                                                      | PATIENT'S PHONE                       | PATIENT'S INSURANCE                                                   |
| ORDERING CLINICIAN                                                           | CLINICIAN SIGNATURE                   |                                                                       |
| SEND ADDITIONAL COPIES OF REPORT TO                                          |                                       |                                                                       |
| REASON FOR EXAM AND ANY SPECIFIC REQUESTS. INCLUDE ICD9 CODE(S) IF AVAILABLE |                                       |                                                                       |

| CT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     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| <input type="checkbox"/> IV Contrast <input type="checkbox"/> No IV Contrast<br><input type="checkbox"/> With and Without IV Contrast<br><input type="checkbox"/> Contrast at Radiologist Discretion<br><br><b>BUN/Creatinine</b> _____<br><i>[Age 60+ or Prior Renal History]</i><br><br><input type="checkbox"/> Head<br><input type="checkbox"/> Maxillo-Facial<br><input type="checkbox"/> Sinus Complete <input type="checkbox"/> Sinus Limited<br><input type="checkbox"/> Sinus Navigator <input type="checkbox"/> GE Nav<br><input type="checkbox"/> Stealth Nav<br><input type="checkbox"/> IACs/Temporal Bone/Pituitary<br><input type="checkbox"/> Orbits<br><input type="checkbox"/> Neck (Soft Tissue)<br><input type="checkbox"/> Chest/Thoracic <input type="checkbox"/> PE Chest<br><input type="checkbox"/> Chest, Abdomen & Pelvis<br><input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Both<br><input type="checkbox"/> 4-Phase Liver<br><input type="checkbox"/> Renal Stone Study<br><input type="checkbox"/> CT IVP (CT Urogram)<br><input type="checkbox"/> CT BE (Barium Enema)<br><input type="checkbox"/> CT Enterography (Small Bowel Eval.)<br><input type="checkbox"/> C-Spine <input type="checkbox"/> T-Spine<br><input type="checkbox"/> L-Spine <input type="checkbox"/> Myelogram<br><input type="checkbox"/> Extremity _____ <input type="checkbox"/> R <input type="checkbox"/> L<br><input type="checkbox"/> 3D Reconstruction<br><input type="checkbox"/> Virtual Colonoscopy<br><input type="checkbox"/> Cardiac Calcium Scoring<br><br><b>Vascular</b><br><input type="checkbox"/> Intracranial/Circle of Willis<br><input type="checkbox"/> Carotids<br><input type="checkbox"/> Carotids & Circle of Willis<br><input type="checkbox"/> Renal<br><input type="checkbox"/> Mesenteric<br><input type="checkbox"/> Aortogram<br><input type="checkbox"/> Thoracic<br><input type="checkbox"/> Abdominal (incl. Iliac AA)<br><input type="checkbox"/> Lower Extremity Runoff (incl. Aorta)<br><input type="checkbox"/> Lower Extremity Only Runoff<br><input type="checkbox"/> Other _____<br><br><b>PET</b><br>Special order form required.<br>Download at <a href="http://imagingak.com">imagingak.com</a> . | <input type="checkbox"/> Carotid<br><input type="checkbox"/> Thyroid <input type="checkbox"/> Thyroid Bx <input type="checkbox"/> FNA<br><input type="checkbox"/> Abdominal (GB, Liver, Pancreas, Spleen, Renal, Aorta/Retroperitoneum)<br><input type="checkbox"/> Renal/Bladder<br><input type="checkbox"/> Pelvic w/Transvaginal <input type="checkbox"/> Pelvic Only<br><input type="checkbox"/> Obstetric EDC ___ LMP ___ BPP ___<br><input type="checkbox"/> Scrotum/Testicular<br><input type="checkbox"/> Venous Doppler <b>Arms:</b> <input type="checkbox"/> R <input type="checkbox"/> L<br><b>Legs:</b> <input type="checkbox"/> R <input type="checkbox"/> L<br><br><input type="checkbox"/> Varicose Vein Reflux Study (Eval. & Treatment)<br><input type="checkbox"/> Varicose Vein Reflux Study Only<br><input type="checkbox"/> Sclerotherapy<br><input type="checkbox"/> Limited _____<br><input type="checkbox"/> Paracentesis <input type="checkbox"/> Thoracentesis<br><input type="checkbox"/> Vein Mapping <b>Arms:</b> <input type="checkbox"/> R <input type="checkbox"/> L<br><b>Legs:</b> <input type="checkbox"/> R <input type="checkbox"/> L<br><br><input type="checkbox"/> ABI w/ Toe Pressure (S. Anchorage and Mat-Su Trunk Rd)<br><input type="checkbox"/> ABI Only (S. Anchorage and Mat-Su Trunk Rd)<br><input type="checkbox"/> Other _____<br><br><b>NUCLEAR MEDICINE</b><br><input type="checkbox"/> Bone Scan<br><input type="checkbox"/> Whole Body <input type="checkbox"/> Limited<br><input type="checkbox"/> 3 Phase Bone Scan<br><input type="checkbox"/> Thyroid Uptake w/Scan<br><input type="checkbox"/> Thyroid Therapy<br><input type="checkbox"/> Whole Body/131I Imaging (Thyroid Met)<br><input type="checkbox"/> Parathyroid Imaging<br><input type="checkbox"/> White Blood Cell Scan<br><input type="checkbox"/> Whole Body <input type="checkbox"/> Limited<br><input type="checkbox"/> Gastric Emptying<br><input type="checkbox"/> Hepatobiliary (HIDA)<br><input type="checkbox"/> w/GB Ejection Fraction (CCK)<br><input type="checkbox"/> Renal Scan<br><input type="checkbox"/> w/Lasix <input type="checkbox"/> DMSA<br><input type="checkbox"/> Liver/Spleen Imaging<br><input type="checkbox"/> MUGA, Gated Heart Imaging<br><input type="checkbox"/> Myocardial Stress Test and Rest<br><input type="checkbox"/> Treadmill <input type="checkbox"/> Adenosine<br><input type="checkbox"/> Other _____ | <input type="checkbox"/> IV Contrast <input type="checkbox"/> No IV Contrast<br><input type="checkbox"/> With and Without IV Contrast<br><input type="checkbox"/> Contrast at Radiologist Discretion<br><br><b>Neurologic/Spine</b><br><input type="checkbox"/> Brain<br><input type="checkbox"/> Orbits<br><input type="checkbox"/> Pituitary<br><input type="checkbox"/> Internal Auditory Canal<br><input type="checkbox"/> Soft Tissue Neck<br><input type="checkbox"/> Brachial Plexus<br><input type="checkbox"/> Metastatic Spine Survey<br><input type="checkbox"/> C-Spine <input type="checkbox"/> T-Spine <input type="checkbox"/> L-Spine*<br>Reason (check one):<br><input type="checkbox"/> Disc <input type="checkbox"/> Infection <input type="checkbox"/> MS <input type="checkbox"/> Mets<br>*History of prior lumbar surgery?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>Date Mo/Yr _____<br><input type="checkbox"/> Sacrum/Coccyx/SI Jts.<br><br><table border="0"> <tr> <td><b>MSK</b></td> <td>R</td> <td>L</td> <td>Arthrogram</td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Elbow</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Wrist</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Hip</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Femur</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Knee</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Tib/Fib</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Ankle</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Foot</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table><br><b>Body</b><br><input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis<br><input type="checkbox"/> Routine Liver with Gadolinium<br><input type="checkbox"/> Liver to Evaluate Lesion<br><input type="checkbox"/> MRCP<br><input type="checkbox"/> Renal <input type="checkbox"/> Adrenal <input type="checkbox"/> Pancreas<br><br><b>Vascular</b><br><input type="checkbox"/> Intracranial/Circle of Willis<br><input type="checkbox"/> MRV<br><input type="checkbox"/> Carotids<br><input type="checkbox"/> Renal MRA<br><input type="checkbox"/> Aortogram<br><input type="checkbox"/> Thoracic<br><input type="checkbox"/> Abdominal <input type="checkbox"/> with Runoff<br><input type="checkbox"/> Other _____ | <b>MSK</b>               | R | L | Arthrogram | <input type="checkbox"/> Shoulder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Elbow | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Wrist | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Hip | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Femur | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Knee | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Tib/Fib | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Ankle | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Foot | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Location of abnormality:</b><br><br><br><b>Digital Mammography</b><br><input type="checkbox"/> Screening <input type="checkbox"/> Diagnostic<br><input type="checkbox"/> Cone Down/Magnification Views<br><input type="checkbox"/> R <input type="checkbox"/> L<br><br><b>Breast Ultrasound</b><br><input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> If Needed<br><br><input type="checkbox"/> Ultrasound Guided Biopsy<br><input type="checkbox"/> Stereotactic Breast Bx (Mat-Su Trunk Rd office only)<br><br><b>DEXA</b><br><input type="checkbox"/> DEXA (Mat-Su offices only)<br><br><b>X-RAY</b><br><input type="checkbox"/> Chest <input type="checkbox"/> AP <input type="checkbox"/> PA/Lateral<br><input type="checkbox"/> Abdomen (KUB)<br>_____ 1 View _____ 2 View<br>Ribs _____<br>Extremity: _____ R L<br>_____ <input type="checkbox"/> <input type="checkbox"/><br>_____ <input type="checkbox"/> <input type="checkbox"/><br><br><input type="checkbox"/> Sinus Series <input type="checkbox"/> Waters Only<br><input type="checkbox"/> Skull<br><input type="checkbox"/> Nasal Bones<br><input type="checkbox"/> Orbits<br><input type="checkbox"/> Pelvis<br><input type="checkbox"/> Hip: <input type="checkbox"/> R <input type="checkbox"/> L<br><input type="checkbox"/> Standing Knees AP<br><input type="checkbox"/> Other _____<br><br>Spine:<br><input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar<br><input type="checkbox"/> With Flexion & Extension<br><input type="checkbox"/> Scoliosis Series<br><input type="checkbox"/> Obliques |
| <b>MSK</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             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**SOUTH ANCHORAGE**  
FAX 222.0201 • TEL 222.0200

**MAT-SU BOGARD RD**  
FAX 357.1222 • TEL 357.1220

[WWW.IMAGINGAK.COM](http://WWW.IMAGINGAK.COM)

**EAST ANCHORAGE**  
FAX 330.1222 • TEL 330.1220

**MAT-SU TRUNK RD**  
FAX A 746.4640 • TEL 746.4646  
FAX B 746.4653

### PATIENT INSTRUCTIONS

Below are instructions to follow prior to your procedure. Please call to schedule and pre-register for your appointment. We're also happy to answer any questions you may have.

#### MRI

Patients will be asked to remove all metal from their person, (i.e., earrings, watches, hairpins, barrettes) and credit cards. Lockers are provided. It is helpful if patient's clothing is comfortable (i.e., sweats) and doesn't include metal buttons, snaps, or zippers.

For MRCPs, MRAs of abdomen and renals, or MRIs of the liver, pelvis and abdomen: The patient should not have anything to eat or drink (including water) 4 hours prior to exam.

#### ULTRASOUND

For abdomen, aorta, liver transplant, mesenteric duplex, portal-hepatic duplex, TIPS evaluation, or renal arterial duplex: Do not eat or drink (including water) after midnight the evening before the exam. For renal and pelvic prep: The patient should drink 32 oz. of water 1 hour prior to the exam without voiding.

NO PATIENT PREP is necessary for the following ultrasound procedures: breast, carotid duplex, cranial, testicular, venous duplex, groin duplex, venous reflux evaluation, and vein mapping.

#### CT

##### CT of Pelvis or Abdomen & Pelvis

- Abdomen
- Pelvis
- Multi-phase Liver
- Abdomen: Pancreatic or Gastric Tumor

Please call the IAP location where your appointment is scheduled for CT prep instructions:

- For exams scheduled at South Anchorage, call 222-0200
- For exams scheduled at East Anchorage, call 330-1220
- For exams scheduled at Mat-Su Trunk Rd., call 746-4646
- For exams scheduled at Mat-Su Bogard Rd., call 357-1220

##### BE CT (rule out appendicitis)

No oral contrast if exam is same day. Otherwise, please call us as instructed above.

##### CT Enterography

Patient needs to arrive at our office 1 hour prior to exam for oral contrast.

##### Other CT Procedures

Including:

- CT IVP
- CTA
- ADB&PEL w/Runoff
- ABD&PEL "AAA"
- ABDOMEN "Adrenal Mass"

If no oral contrast is indicated for your particular CT, simply do not eat or drink anything for at least 4 hours prior to your exam.

#### MAMMOGRAPHY

Do not wear deodorant, powder, or lotion.

#### PET

Please see our separate PET patient instructions, available at [www.imagingak.com](http://www.imagingak.com).

#### LOCATIONS

For maps and directions, visit [www.imagingak.com/contact\\_us](http://www.imagingak.com/contact_us).

##### SOUTH ANCHORAGE

On Abbott between Fred Meyer and the Tesoro station.  
2000 Abbott Road, Suite 102 Anchorage, AK 99507  
TEL 907.222.0200  
800.818.9392  
FAX 907.222.0201

##### EAST ANCHORAGE

On Debarr between Turpin and Patterson streets.  
6911 Debarr Road Anchorage, AK 99504  
TEL 907.330.1220  
FAX 907.330.1222

##### MAT-SU TRUNK RD

Just off the Trunk Road exit on S. Woodworth Loop.  
2280 S. Woodworth Loop Palmer, AK 99645  
TEL 907.746.4646  
800.945.9392  
FAX 907.746.4640

##### MAT-SU BOGARD

Just off Bogard Road, east of Wasilla High School.  
1751 E. Gardner Way, Suite B Wasilla, AK 99654  
TEL 907.357.1220  
FAX 907.357.1222