

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

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

**S. ANCHORAGE**

2000 Abbott Road, Suite 102

**TEL** 907.222.0200

**FAX** 907.222.0201

- MRI (3T)     Venacure  
 X-Ray         Mamm  
 CT              Ultrasound

**E. ANCHORAGE**

6911 Debarr Road

**TEL** 907.330.1220

**FAX** 907.330.1222

- Open MRI  
 Ultrasound  
 CT

**MAT-SU TRUNK RD**

2280 S. Woodworth Loop

**TEL** 907.746.4646

**FAX** 907.746.4640

- MRI (1.5T)     Bone Density  
 X-Ray         Mamm  
 CT              Ultrasound

**MAT-SU BOGARD RD**

1751 E. Gardner Way, Suite B

**TEL** 907.357.1220

**FAX** 907.357.1222

- MRI (1.5T)     CT  
 Nuclear Medicine     X-Ray  
 Bone Density         Ultrasound

*PET scans available at E. Anchorage and Mat-Su Bogard Rd.; please download PET order form at [www.imagingak.com](http://www.imagingak.com).*

Exam Requested \_\_\_\_\_ DX Codes \_\_\_\_\_

BUN/Creatinine Level (CT & MRI) [*Age 60+ or Prior Renal History*] \_\_\_\_\_ Date Drawn \_\_\_\_\_

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

Note to Technologist \_\_\_\_\_

- Contrast Exam as Necessary       Please Deliver CD to Provider Office       Send Films with Patient  
 Weight Bearing                       Stat Call Report                                   Send CD with Patient

Referring Provider \_\_\_\_\_ Phone \_\_\_\_\_

Staff Member Ordered By \_\_\_\_\_ Fax \_\_\_\_\_

*Thanks for entrusting us with your patient. Expect a preliminary report within 1 hour of physician reading.*

