



ACADIANA IMAGING CENTER - SOUTH

2311 Kaliste Saloom Road • Lafayette, LA
(Across from Randol's Restaurant)

Fax 337-231-5776 • Phone 337-231-5775

MR-High Field, CT, X-Ray, Fluoroscopy, PET/CT

ACADIANA IMAGING CENTER - CENTRAL

501 W. St. Mary • Ste. 108 • Lafayette, LA
(St. Francis Bldg behind Our Lady of Lourdes)

Fax 337-231-5567 • Phone 337-231-5775

Open MRI

ST. MARY'S IMAGING CENTER

411 St. Landry Street • Lafayette, LA
(next to Our Lady of Lourdes)

Fax 337-289-2782 • Phone 337-289-2024

MR-High Field (including Breast), CT, Nuc Med, Ultrasound, X-ray, Fluoroscopy

Patient Name _____ Appt. Date: _____ Time: _____ AM PM

Ordering Physician _____ Diagnosis _____

Allergic to Iodine? YES NO Prior Exams done? YES NO Where? _____

Diabetic? YES NO If Yes, need BUN/Creatinine results faxed over with orders _____

*If your patient has had surgery on the area being scanned or a history of cancer, please notify us.

NOTE: PATIENTS' PREVIOUS TEST FILMS ARE NECESSARY FOR COMPARISON TO GET THE MOST ACCURATE RESULTS.

Comments _____

MRI	w/o	with
<input type="checkbox"/> Brachial Plexus <input type="checkbox"/> RT <input type="checkbox"/> LT	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> MR Arthrogram (specify) _____		
<input type="checkbox"/> Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Brain	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Breast	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cervical	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chest	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cholangiogram (MRCP)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Female Pelvis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hip/Hips <input type="checkbox"/> RT <input type="checkbox"/> LT	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> IAC's	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Knee <input type="checkbox"/> RT <input type="checkbox"/> LT	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lumbar	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Orbit	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pelvis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Shoulder <input type="checkbox"/> RT <input type="checkbox"/> LT	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Soft Tissue Neck	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pituitary/Sella	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Upper Ext <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Bilat	<input type="checkbox"/>	<input type="checkbox"/>
Specify location _____		
<input type="checkbox"/> Lower Ext <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Bilat	<input type="checkbox"/>	<input type="checkbox"/>
Specify location _____		
<input type="checkbox"/> Other: _____		

NUC MED
<input type="checkbox"/> Bone Scan
<input type="checkbox"/> Bone/3 Phase Specify location _____
<input type="checkbox"/> Brain/Spect
<input type="checkbox"/> Brain with flow
<input type="checkbox"/> Gastric Emptying <input type="checkbox"/> Solids <input type="checkbox"/> Liquids <input type="checkbox"/> Both
<input type="checkbox"/> GI Bleed (RBC)
<input type="checkbox"/> Hida
<input type="checkbox"/> Hida E/F
<input type="checkbox"/> Liver/Spleen
<input type="checkbox"/> Meckels
<input type="checkbox"/> Muga
<input type="checkbox"/> Octreoscan
<input type="checkbox"/> Parathyroid
<input type="checkbox"/> Renal <input type="checkbox"/> Quantitative <input type="checkbox"/> Vasotec <input type="checkbox"/> w/Lasix <input type="checkbox"/> Renal GFR
<input type="checkbox"/> SPECT Specify Location _____
<input type="checkbox"/> Tagged RBC Liver
<input type="checkbox"/> Tagged WBC <input type="checkbox"/> Ceretec <input type="checkbox"/> IN III <input type="checkbox"/> GA-67
<input type="checkbox"/> Thyroid-TCO4+
<input type="checkbox"/> Thyroid-I-123-Uptake
<input type="checkbox"/> Whole Body Thyroid
<input type="checkbox"/> Other: _____

CT	w/o	with
<input type="checkbox"/> Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cervical Spine	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chest	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Extremity Lower <input type="checkbox"/> RT <input type="checkbox"/> LT	<input type="checkbox"/>	<input type="checkbox"/>
Specify Location _____		
<input type="checkbox"/> Extremity Upper <input type="checkbox"/> RT <input type="checkbox"/> LT	<input type="checkbox"/>	<input type="checkbox"/>
Specify Location _____		
<input type="checkbox"/> Head/Brain	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pelvis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sinus	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Soft Tissue Neck	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Temporal Bones	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hips	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Abdomen/Pelvis Renal Stone Survey	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other: _____		

CTA
<input type="checkbox"/> Abdomen
<input type="checkbox"/> AA/Runoff
<input type="checkbox"/> Carotids
<input type="checkbox"/> Head/COW
<input type="checkbox"/> Renals
<input type="checkbox"/> Chest
<input type="checkbox"/> Other: _____

MRA	w/o	with
<input type="checkbox"/> Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Brain	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chest	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neck/Carotid	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Renals	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> MRV Brain (Venous Flow)	<input type="checkbox"/>	<input type="checkbox"/>

PET / CT
<input type="checkbox"/> Standard Body Study (Skull base to Thigh) Special (Non-Standard)
<input type="checkbox"/> Limited Body (Chest etc.)
<input type="checkbox"/> Whole Body (skull vertex to toes) For known or suspected lower ext tumors i.e., Melanoma, Squamous Cell Ca.
<input type="checkbox"/> Brain only (Alzheimers, Brain tumors)
<input type="checkbox"/> Myocardial Imaging (Cardiac Viability)

DIAGNOSTIC RADIOLOGY (X-RAYS)

<input type="checkbox"/> Abdomen Flat & Upright	<input type="checkbox"/> Metastatic Series
<input type="checkbox"/> Abdomen KUB	<input type="checkbox"/> Nasal Bones
<input type="checkbox"/> Acromioclavicular Joint	<input type="checkbox"/> Orbits
<input type="checkbox"/> Ankle	<input type="checkbox"/> Pelvis
<input type="checkbox"/> Bone Age	<input type="checkbox"/> Ribs
<input type="checkbox"/> Bone Length Study	<input type="checkbox"/> Sacroiliac JTs
<input type="checkbox"/> Calcaneus	<input type="checkbox"/> Sacrum/Coccyx
<input type="checkbox"/> Cephalogram	<input type="checkbox"/> Scapula
<input type="checkbox"/> CXR <input type="checkbox"/> PA	<input type="checkbox"/> Sinus
<input type="checkbox"/> PA/LAT	<input type="checkbox"/> Shoulder
<input type="checkbox"/> APICAL LORDOTIC	<input type="checkbox"/> Skull
<input type="checkbox"/> Clavicle	<input type="checkbox"/> Soft Tissue Neck
<input type="checkbox"/> Elbow	<input type="checkbox"/> Spine: Cervical
<input type="checkbox"/> Facial Bones	<input type="checkbox"/> 3V <input type="checkbox"/> 5V <input type="checkbox"/> 7V
<input type="checkbox"/> Femur	<input type="checkbox"/> w/Flex/Ext
<input type="checkbox"/> Finger	<input type="checkbox"/> Spine: Lumbar
Specify _____	<input type="checkbox"/> 3V <input type="checkbox"/> 5V <input type="checkbox"/> 7V
<input type="checkbox"/> Foot	<input type="checkbox"/> w/Flex/Ext
<input type="checkbox"/> Forearm	<input type="checkbox"/> Spine: Thoracic
<input type="checkbox"/> Hand	<input type="checkbox"/> Spine: Scoliosis
<input type="checkbox"/> Hip	<input type="checkbox"/> Sterenoclavicular Joints
<input type="checkbox"/> Humerus	<input type="checkbox"/> Sternum
<input type="checkbox"/> Knee	<input type="checkbox"/> Tibia & Fibula <input type="checkbox"/> RT <input type="checkbox"/> LT
<input type="checkbox"/> Knee-Standing	<input type="checkbox"/> Toe <input type="checkbox"/> RT <input type="checkbox"/> LT
<input type="checkbox"/> Mandible	Specify _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Wrist <input type="checkbox"/> RT <input type="checkbox"/> LT

FLUOROSCOPY
<input type="checkbox"/> BE
<input type="checkbox"/> BE w/Air
<input type="checkbox"/> Esophogram
<input type="checkbox"/> Esophogram w/13mm tablet
<input type="checkbox"/> SBS
<input type="checkbox"/> UGI
<input type="checkbox"/> IVP
<input type="checkbox"/> Arthrogram Specify Location _____
<input type="checkbox"/> Myelogram/CT <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Cervical Spine
<input type="checkbox"/> Other: _____

ULTRASOUND
<input type="checkbox"/> Abdomen-Complete
<input type="checkbox"/> Arterial Lower Ext <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Bilat
<input type="checkbox"/> Arterial Upper Ext <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Bilat
<input type="checkbox"/> Carotid
<input type="checkbox"/> Extremity <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Bilat
<input type="checkbox"/> Gallbladder
<input type="checkbox"/> Groin
<input type="checkbox"/> Hysterosonogram
<input type="checkbox"/> Kidneys
<input type="checkbox"/> Liver
<input type="checkbox"/> Neck
<input type="checkbox"/> OB Complete
<input type="checkbox"/> Pelvis (also with Endovaginal if needed)
<input type="checkbox"/> Renal Doppler
<input type="checkbox"/> Testes/Scrotum
<input type="checkbox"/> Thyroid/Parathyroid
<input type="checkbox"/> Venous Lower Ext <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Bilat
<input type="checkbox"/> Venous Upper Ext <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Bilat
<input type="checkbox"/> Other Specify: _____



LOURDES IMAGING NETWORK

Healthcare to the **HIGHEST** Power.™

