

Patient Name _____ DOB _____

Appointment Date and Time _____

Provider's Signature _____ Print Name _____

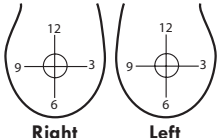
Preauthorization # _____ CMS AUC# _____
(if applicable) (if applicable)

Indication for Exam _____

Call Patient to Schedule Hold and Call

Comments/Special Instructions _____

MRI/MRA	CT/CTA	Ultrasound
<input type="checkbox"/> Draw Creatinine - Current Creatinine Within 45 Days Creatinine _____ Draw Date _____ <input type="checkbox"/> w/contrast <input type="checkbox"/> w/o contrast <input type="checkbox"/> w & w/o contrast <input type="checkbox"/> Breast <input type="checkbox"/> L-Spine <input type="checkbox"/> Brain <input type="checkbox"/> Abdomen <input type="checkbox"/> Brain w/Orbits <input type="checkbox"/> Pelvis <input type="checkbox"/> Brain w/IAC <input type="checkbox"/> MRCP <input type="checkbox"/> Neck (Soft Tissue) <input type="checkbox"/> MRA <input type="checkbox"/> C-Spine <input type="checkbox"/> MRV <input type="checkbox"/> T-Spine <input type="checkbox"/> MR Enterography <input type="checkbox"/> Extremity specify _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> Draw Creatinine - Current Creatinine Within 30 Days Creatinine _____ Draw Date _____ <input type="checkbox"/> w/contrast <input type="checkbox"/> w/o contrast <input type="checkbox"/> w & w/o contrast <input type="checkbox"/> Brain <input type="checkbox"/> C-Spine <input type="checkbox"/> Facial Bones/Sinus <input type="checkbox"/> T-Spine <input type="checkbox"/> Orbits <input type="checkbox"/> L-Spine <input type="checkbox"/> Neck (Soft Tissue) <input type="checkbox"/> Renal Stone <input type="checkbox"/> Chest <input type="checkbox"/> Urogram <input type="checkbox"/> Abdomen <input type="checkbox"/> Cardiac Score <input type="checkbox"/> Pelvis <input type="checkbox"/> Virtual Colonoscopy <input type="checkbox"/> CT Anglo specify _____ <input type="checkbox"/> Extremity specify _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> Pelvic Transabdominal (TA) <input type="checkbox"/> Pelvic Transvaginal (TV) <input type="checkbox"/> Abdominal (Limited or Complete) <input type="checkbox"/> Breast <input type="checkbox"/> OB Ultrasound < 14 weeks <input type="checkbox"/> OB Ultrasound >14 weeks <input type="checkbox"/> OB Ultrasound Follow Up or FU <input type="checkbox"/> Scrotal/Testicular <input type="checkbox"/> Aorta (AAA) <input type="checkbox"/> Thyroid <input type="checkbox"/> Renal (Kidney) <input type="checkbox"/> Renal With Doppler <input type="checkbox"/> Sonohysterogram <input type="checkbox"/> Extremity specify _____
Fluoroscopy	Arthrography	General X-Ray
<input type="checkbox"/> Esophagram <input type="checkbox"/> Upper GI <input type="checkbox"/> Small Bowel <input type="checkbox"/> Barium Enema <input type="checkbox"/> Hysterosalpingogram <input type="checkbox"/> Joint Injection specify _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> CT Arthrogram <input type="checkbox"/> MR Arthrogram <input type="checkbox"/> Conventional Arthrogram <input type="checkbox"/> Extremity specify _____ <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Facial Bones <input type="checkbox"/> Hip <input type="checkbox"/> Mandible <input type="checkbox"/> Pelvis <input type="checkbox"/> Nasal Bones <input type="checkbox"/> Sacrum/Coccyx <input type="checkbox"/> Sinus Series <input type="checkbox"/> Scoliosis Series <input type="checkbox"/> Skull <input type="checkbox"/> Abdomen (KUB) <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen Flat & Upright <input type="checkbox"/> Spine <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Extremity specify _____ <input type="checkbox"/> Other _____

Breast Imaging	Bone Density	Biopsy
<input type="checkbox"/> Routine Screening <input type="checkbox"/> Baseline <input type="checkbox"/> Diagnostic <input type="checkbox"/> Follow-Up Short-term	<input type="checkbox"/> Palpable Mass or Area of Concern Please indicate on diagram  <input type="checkbox"/> Bone Density (DEXA) <input type="checkbox"/> Menopausal Status _____ <input type="checkbox"/> Hormonal Replacement or Long-Term Drug Therapy <input type="checkbox"/> Hx of Pathologic Fractures	<input type="checkbox"/> Stereotactic Breast <input type="checkbox"/> Ultrasound Guided <input type="checkbox"/> Breast <input type="checkbox"/> Thyroid (FNA)



Diagnostic & Preventative Imaging Center

Our Focus is Your Good Health

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IowaRadiology.com

General Business Hours

Monday - Friday 8:00am - 5:00pm

**Saturday appointments available
for Mammograms**

	Clive	Downtown	Ankeny	Lakeview
MRI/MRA	X		X	
CT/CTA	X	X	X	
Breast Imaging	X	X	X	
Ultrasound	X	X	X	
Bone Density	X		X	
Fluoroscopy	X	X	X	
Arthrography	X	X	X	
General X-Ray	X	X	X	X
Biopsy	X	X		

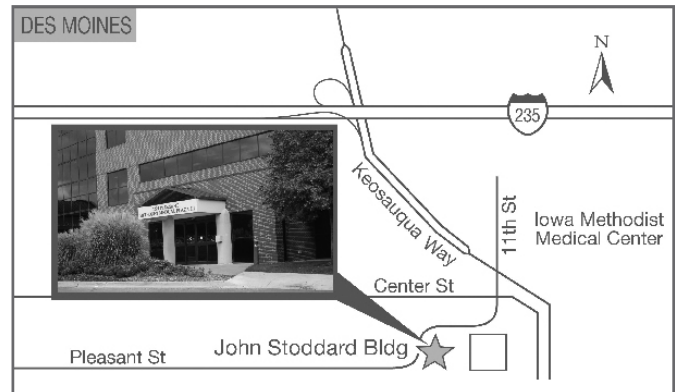


Clive Office:

12368 Stratford Drive, Suite 300 • Clive, Iowa 50325
From I-80, Exit west onto University Avenue. Turn north onto 124th Street. We are the second building on the east side of the road.

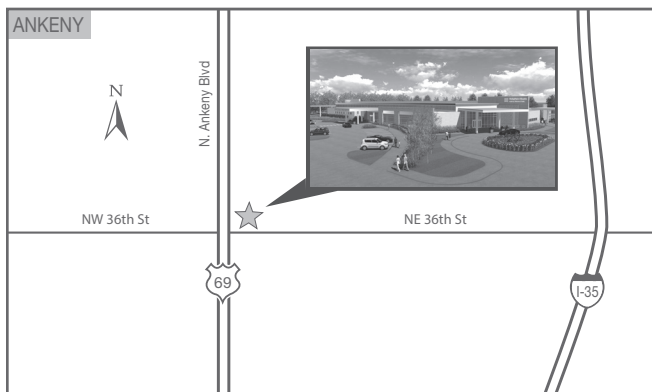
Lakeview: General X-Ray Only • Walk-ins Welcome
6000 University Avenue, Suite 150
West Des Moines, Iowa 50266

Located on the corner of 60th Street and University Avenue, on the first floor.



Downtown Office:

1221 Pleasant, Street, Suite 350 • Des Moines, Iowa 50309
From I-235, Exit south on Keo Way. Follow hospital signs to Methodist Hospital. We are located in Suite 350 of the John Stoddard Building. (Free parking is available in the parking garage west of the building)



North Ankeny Medical Park Office:

3625 N Ankeny Blvd., Suite H • Ankeny, Iowa 50023
From I-35, Exit west on 36th St. (exit # 94). Go west approximately 1 1/2 miles and turn right (north) into the Unity Point Ankeny Medical Park. We are located inside of the Ankeny Medical Park on the northeast corner of Ankeny Blvd. and 36th Street.