



☐ **OVERLAND PARK**
11717 W 112TH STREET
OVERLAND PARK, KS 66210
913.469.8998

☐ **LEAWOOD**
11221 ROE AVE #220
LEAWOOD, KS 66211
913.469.8998

☐ **LEE'S SUMMIT**
3210 NE CARNEGIE DRIVE
LEE'S SUMMIT, MO 64064
816.841.9775

☐ **LIBERTY**
9778 NORTH ASH AVE
KANSAS CITY, MO 64157
816.934.4758

elementimaging.com
F 913.469.5695

Please include: PATIENT INSURANCE, DEMOGRAPHICS and CLINICAL NOTES

Patient Name: _____ Birth Date: _____ Today's Date: _____

Cell Phone: _____ Alt Phone: _____ Clinical Indications/Diagnosis: _____

Primary Insurance: _____ Member ID: _____

PRIOR AUTHORIZATION ☐ Referring Office to pre-cert **attach documentation* ☐ EMI to pre-cert **attach signed clinical notes & copy of insurance card*

Signature of Referring Physician

Referring Practice Name

Referring Physician Printed Name

Referral Coordinator/Contact Number

CALL REPORTS ☐ YES ☐ NO

NUMBER _____

MRI	CONTRAST: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Radiologist Discretion	MRA / MRV <input type="checkbox"/> MRA Head <input type="checkbox"/> MRV Head <input type="checkbox"/> MRA Neck <input type="checkbox"/> MRV Neck (Carotids) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____	ORTHOPAEDIC <input type="checkbox"/> Post Arthrogram? Yes/No <input type="checkbox"/> Shoulder LT RT Bilat <input type="checkbox"/> Elbow LT RT Bilat <input type="checkbox"/> Wrist LT RT Bilat <input type="checkbox"/> Hip LT RT Bilat <input type="checkbox"/> Knee LT RT Bilat <input type="checkbox"/> Ankle LT RT Bilat <input type="checkbox"/> Foot LT RT Bilat <input type="checkbox"/> Other: _____	BODY <input type="checkbox"/> Breast <input type="checkbox"/> Fast Breast* <input type="checkbox"/> Breast Implant Rupture Screening <input type="checkbox"/> Abdomen <input type="checkbox"/> MRCP <input type="checkbox"/> Enterography <input type="checkbox"/> Pelvis <input type="checkbox"/> Prostate <input type="checkbox"/> Other: _____
	HEAD / NECK <input type="checkbox"/> Brain with & without contrast <input type="checkbox"/> MS <input type="checkbox"/> Orbits <input type="checkbox"/> Pituitary <input type="checkbox"/> Therapy Planning <input type="checkbox"/> IAC's <input type="checkbox"/> Brain without contrast <input type="checkbox"/> TMJ <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Brachial Plexus	SPINE <input type="checkbox"/> Cervical <input type="checkbox"/> Lumbar/Sacrum <input type="checkbox"/> Thoracic <input type="checkbox"/> Sacrum/Coccyx		

CT	CONTRAST: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> With and Without <input type="checkbox"/> Radiologist Discretion	CTA (ANGIOGRAPHY) <input type="checkbox"/> CTA Brain/Head <input type="checkbox"/> CTA Carotid/Vertebral (Arch/Neck) <input type="checkbox"/> CTA Thoracic Aorta (Chest) <input type="checkbox"/> CTA Chest for PE <input type="checkbox"/> CTA Renal <input type="checkbox"/> CTA Abdomen <input type="checkbox"/> CTA Pelvis <input type="checkbox"/> CTA Aorta with Runoff
	<input type="checkbox"/> Arthrogram <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Sella/Temporal/IAC's <input type="checkbox"/> Sinus Complete <input type="checkbox"/> Sinus Landmark <input type="checkbox"/> Denta Scan/Mandible <input type="checkbox"/> Facial Bones/Maxillofacial <input type="checkbox"/> Pulmonary Nodule Follow-up	<input type="checkbox"/> Chest <input type="checkbox"/> Cardiac Score* <input type="checkbox"/> Lung Cancer Screening <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Abdomen & Pelvis <input type="checkbox"/> Urogram <input type="checkbox"/> Renal Stone <input type="checkbox"/> Enterography <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Extremity LT RT _____ <input type="checkbox"/> Scanogram <input type="checkbox"/> Other: _____ <input type="checkbox"/> CTA Upper Extremity <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> CTA Lower Extremity <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B

ULTRASOUND	<input type="checkbox"/> Abdomen <input type="checkbox"/> Renal <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Thyroid <input type="checkbox"/> Testes <input type="checkbox"/> Prostate <input type="checkbox"/> Hernia <input type="checkbox"/> Abdominal Wall <input type="checkbox"/> Inguinal <input type="checkbox"/> Extremity: _____	<input type="checkbox"/> Pelvic Only <input type="checkbox"/> Pelvic/TV (if needed) <input type="checkbox"/> TV Only <input type="checkbox"/> Follicular Count - TV Only <input type="checkbox"/> Breast LT RT B	DOPPLERS <input type="checkbox"/> Carotid LT RT B <input type="checkbox"/> Arterial Arm LT RT B <input type="checkbox"/> Arterial Leg LT RT B <input type="checkbox"/> Venous Arm LT RT B <input type="checkbox"/> Venous Leg LT RT B <input type="checkbox"/> Abd Aorta/Iliac <input type="checkbox"/> Abdominal <input type="checkbox"/> Renal Artery	US GUIDED BIOPSY <input type="checkbox"/> Cyst Aspiration <input type="checkbox"/> Axillary Node <input type="checkbox"/> Breast L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Thyroid <input type="checkbox"/> Soft Tissue Mass	BREAST IMAGING	<input type="checkbox"/> Screening Mammogram <input type="checkbox"/> Ultrasound and/or Diagnostic MM if needed <input type="checkbox"/> Diagnostic MM LT RT Bilat <input type="checkbox"/> Ultrasound if needed <input type="checkbox"/> Breast Ultrasound LT RT Bilat <input type="checkbox"/> Breast MRI <input type="checkbox"/> Fast Breast MRI* <input type="checkbox"/> Breast Implant Rupture Screening MRI <input type="checkbox"/> Breast Biopsy LT RT Bilat
		OBSTETRIC <input type="checkbox"/> OB < 14 weeks <input type="checkbox"/> OB > 14 weeks <input type="checkbox"/> OB TV Only				

X-RAY	<input type="checkbox"/> Skull (4v) <input type="checkbox"/> Mandible (4v) <input type="checkbox"/> Facial Bones (3v) <input type="checkbox"/> Sinus (3v) <input type="checkbox"/> Waters view only <input type="checkbox"/> Orbits (4v) <input type="checkbox"/> SC Joints (2v both) <input type="checkbox"/> Cervical Spine (3v) <input type="checkbox"/> Chest (2v)	<input type="checkbox"/> Sternum (2v) <input type="checkbox"/> Abdomen Series (3v) <input type="checkbox"/> KUB <input type="checkbox"/> Pelvis <input type="checkbox"/> SI Joints (3v both) <input type="checkbox"/> AC Joints (2v) <input type="checkbox"/> Scoliosis <input type="checkbox"/> Sacrum/Coccyx (3v) <input type="checkbox"/> Lumbar (3v) <input type="checkbox"/> Lumbar (5v) <input type="checkbox"/> Other: _____	Select Laterality: <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Ribs (4v) <input type="checkbox"/> Shoulder (3v) <input type="checkbox"/> Clavicle (2v) <input type="checkbox"/> Scapula (2v) <input type="checkbox"/> Humerus (2v) <input type="checkbox"/> Elbow (3v) <input type="checkbox"/> Forearm (2v) <input type="checkbox"/> Wrist (3v) <input type="checkbox"/> Hand (3v) <input type="checkbox"/> Finger (3v) <input type="checkbox"/> Thumb (3v) <input type="checkbox"/> Hip (3v) <input type="checkbox"/> Femur (2v) <input type="checkbox"/> Knee (4v) <input type="checkbox"/> Tib/Fib (2v) <input type="checkbox"/> Ankle (3v) <input type="checkbox"/> Foot (3v) <input type="checkbox"/> Toes (3v) <input type="checkbox"/> Bone Age	FLUOROSCOPY	<input type="checkbox"/> Esophagram/Barium Swallow <input type="checkbox"/> Upper GI <input type="checkbox"/> Small Bowel Series <input type="checkbox"/> Other: _____	<input type="checkbox"/> Barium Enema w/ Air <input type="checkbox"/> Voiding Cystogram <input type="checkbox"/> Hysterosalpingogram*
			ARTHROGRAM <input type="checkbox"/> Shoulder LT RT Bilat <input type="checkbox"/> Elbow LT RT Bilat <input type="checkbox"/> Wrist LT RT Bilat <input type="checkbox"/> Hip LT RT Bilat <input type="checkbox"/> Knee LT RT Bilat <input type="checkbox"/> Ankle LT RT Bilat		JOINT INJECTION <input type="checkbox"/> Shoulder LT RT Bilat <input type="checkbox"/> Elbow LT RT Bilat <input type="checkbox"/> Wrist LT RT Bilat <input type="checkbox"/> Hip LT RT Bilat <input type="checkbox"/> Knee LT RT Bilat <input type="checkbox"/> Ankle LT RT Bilat	MYELOGRAM W/CT <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar

*The number of views listed in parentheses are the default unless otherwise indicated

NUCLEAR MEDICINE	<input type="checkbox"/> Bone Scan Limited <input type="checkbox"/> Total Body Bone Scan <input type="checkbox"/> Triple Phase Bone Scan <input type="checkbox"/> Thyroid Scan <input type="checkbox"/> Thyroid Uptake/Scan	<input type="checkbox"/> Parathyroid (sestamibi) <input type="checkbox"/> Renal Scan <input type="checkbox"/> Lasix <input type="checkbox"/> Without Lasix <input type="checkbox"/> Hepatobiliary Scan <input type="checkbox"/> With EF <input type="checkbox"/> Without EF	DEXA/BONE DENSITY	<input type="checkbox"/> Hip/Spine (Routine) <input type="checkbox"/> Body Composition Analysis (BMI)* *BMI performed at Lee's Summit and Liberty Locations	PET/CT	Scan here for the PET order form, or visit elementimaging.com.

*Nuc Med Studies performed only at Overland Park location

*SELF-PAY ONLY

GENERAL INFORMATION

- If you might be pregnant, please call our office before your scheduled appointment.
- If your physician gave you prior exams, please bring them.
- If you have had asthma or any previous reaction to X-ray contrast agents, please call this office at least 2-3 days prior to your scheduled appointment.
- If you have a question regarding your exam or the preparation for the exam, please do not hesitate to call us. A technologist will be available should you need them.
- If for any reason you are unable to keep your appointment, please call 913.469.8998 to notify and reschedule.

PATIENT INSTRUCTIONS

MAMMOGRAM: Do not use deodorants, powders, sprays, or ointments under the arms or on the breast the morning of your exam.

BARIUM ENEMA EXAM: Day before exam take 4 Dulcolax pills between 2-4 pm. Mix 64oz. of Gatorade with Miralax powder. Start drinking between 5-6 pm the evening prior to exam. Clear liquids until midnight, nothing to eat or drink after midnight.

SMALL BOWEL FOLLOW THROUGH - UGI: Nothing to eat or drink after midnight the evening before your exam and the morning of the exam.

CT CONTRAST STUDY: Nothing to eat or drink 4 hours prior to exam time. (Hydrate well the day before.)

CT NO IV CONTRAST STUDY: No Restrictions. If you have an iodine allergy, call 913.754.4708 before your appointment.

ULTRASOUND PELVIS AND/OR OB: For pelvic area and obstetrical exams drink to be completed an hour before the exam. (A full bladder is needed to visualize pelvic organs). Do not urinate before your exam.

ULTRASOUND/ABDOMEN AND/OR GALLBLADDER: For gallbladder and abdominal studies (kidneys, liver and pancreas), eat a low fat meal the evening before (no butter, cream, etc.) Nothing to eat or drink after midnight the night before the exam.

PROSTATE ULTRASOUND: Administer Fleet's enema kit and drink 32 ounces of water to fill bladder one hour before exam.

ULTRASOUND RENAL: Nothing to eat 6 hours prior and drink 20 ounces of water completed 1 hour prior to exam.

DEXA BONE DENSITOMETRY: No preparation.

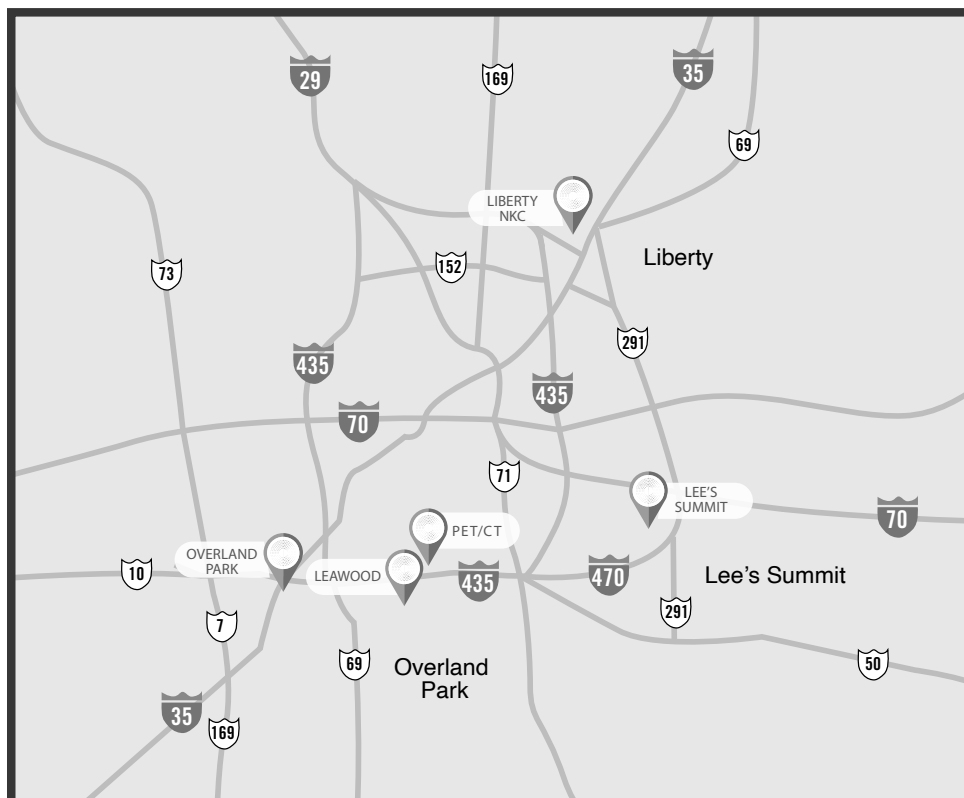
You do not need to discontinue any medication and there are no dietary restrictions for most MRI studies.

MRI STUDIES: Please remove any objects that may be attracted to or damaged by a magnet. This may include jewelry, credit cards, hearing aids, dentures, etc.. Our staff will secure these items in a locker during your examination. Certain individuals with cardiac pacemakers, brain aneurysm clips, a history of metallic fragments in an eye, or certain other implanted devices may not be candidates for MRI due to safety concerns. Please inform the technologist if you believe any of these conditions apply to you.

MRI ABDOMEN AND MRCP: Nothing to eat or drink 8 hours prior.

MRI BREAST: Premenopausal patients scan should be scheduled in the second week of the menstrual cycle (days 7-14) after the first day of the last menstrual period, unless new diagnosis of breast cancer.

ENTEROGRAPHY: Nothing to eat or drink 6 hours prior to exam time. Arrive 2 hours prior to exam time.



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