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Phone (402) 462-4070 Fax (402) 461-8460

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

DIAGNOSIS (required): \_\_\_\_\_

**WOMEN'S IMAGING**

Screening Mammogram  
 with return work up to include additional views and/or ultrasound if indicated

Diagnostic Mammogram                      Right                      Left

Breast Ultrasound                              Right                      Left

Breast MRI    Right                      Left

Breast Biopsy    Right                      Left

Stereotactic

Ultrasound Guided

MRI Guided

**OSTEOPOROSIS TESTING**

DXA Scan

**X-RAY**

Exam: \_\_\_\_\_

\_\_\_\_\_

**ULTRASOUND**

Exam: \_\_\_\_\_

\_\_\_\_\_

**ADDITIONAL COMMENTS/INSTRUCTIONS**

\_\_\_\_\_

\_\_\_\_\_

**MRI SCAN**

Exam: \_\_\_\_\_

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Creatinine?                       Yes                       No

Results: \_\_\_\_\_

Date: \_\_\_\_\_

Pacemaker?                       Yes                       No

Metal Implants?                       Yes                       No

**CT SCAN**

Exam: \_\_\_\_\_

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Creatinine?                       Yes                       No

Results: \_\_\_\_\_

Date: \_\_\_\_\_

Iodine Allergy?                       Yes                       No

**INTERVENTIONAL RADIOLOGY**

Pain Management Consult/Evaluate and Treat for  
(circle one) back pain    neck pain    leg pain  
other (please specify) \_\_\_\_\_

Pain Management Consult/Evaluate and Treat for

facet injection  
specify levels (if known) \_\_\_\_\_

SI joint injection    Right    Left

kyphoplasty/vertebroplasty

other (please specify) \_\_\_\_\_

\_\_\_\_\_

Initial Evaluation for Laser Vein Ablation

Laser Vein Ablation

\_\_\_\_\_  
(ordering physician's signature)

\_\_\_\_\_  
(print name)