



STAT HOLD: Patient held at DCA until referring physician's office verbally releases patient from facility, regardless of results. Verbal results on positive and negative study; fax results within 12 hours.

STAT NO-HOLD: If positive, patient held at DCA until referring physician's office verbally releases patient from facility. Verbal results only on a positive study; fax results within 12 hours.

PRIORITY: We will make every effort to schedule patient same day. Appointments before 4pm will receive faxed results same day, after 4pm results faxed early the next morning.

Wellington Boynton Delray

Date of Request: _____/_____/_____ Appointment Date: _____/_____/_____ Time: _____

CD Requested Film Requested Labs Needed Bun: _____/Creatinine: _____ Date: _____

Diagnosis: _____

Patient's Name: _____

Physician's Name: _____

Patient's Phone: _____

Physician's Phone: _____

Patient's SSN: _____

Physician's Fax: _____

Insurance: _____

Physician's Signature: _____

CT	
<input type="checkbox"/> With <input type="checkbox"/> Without <input type="checkbox"/> With & Without Contrast	
<input type="checkbox"/> Head	
<input type="checkbox"/> Sinuses: ___ Routine ___ Limited	
<input type="checkbox"/> Orbits	
<input type="checkbox"/> Facial Bones/Jaw/TMJ	
<input type="checkbox"/> Temporal Bones/Mastoids	
<input type="checkbox"/> Soft Tissue Neck	
<input type="checkbox"/> Cervical Spine	
<input type="checkbox"/> Thoracic Spine	
<input type="checkbox"/> Lumbar Spine	
<input type="checkbox"/> Chest: ___ Routine ___ PE ___ High Res	
<input type="checkbox"/> Abdomen & Pelvis	
<input type="checkbox"/> CT Abd/Pelvis + KUB + IVP (no oral prep)	
<input type="checkbox"/> Abdomen Only	
<input type="checkbox"/> Pelvis Only	
<input type="checkbox"/> Extremity:	
<input type="checkbox"/> Other:	
CT ANGIOGRAPHY	
<input type="checkbox"/> Brain <input type="checkbox"/> Neck/Carotid	
<input type="checkbox"/> Chest <input type="checkbox"/> Abdomen	
<input type="checkbox"/> Other:	
CARDIAC: Delray & Wellington	
<input type="checkbox"/> Cardiac Score Only	
<input type="checkbox"/> CTA Complete: Score, Structure, Artery	
<input type="checkbox"/> Cardiac Structure/Morphology & Coronary Artery	
<input type="checkbox"/> Triple Rule Out: PE/Coronary Artery	
Disease/Aortic Dissection	
<input type="checkbox"/> Cardiac MRI: Viability	
<input type="checkbox"/> Cardiac MRA: Aneurysm/Dissection	
<input type="checkbox"/> Echocardiogram	
<input type="checkbox"/> EKG Delray Only	
<input type="checkbox"/> Other:	
CT DUAL ENERGY: Delray	
<input type="checkbox"/> Gout: Wrist ___ Foot ___	
<input type="checkbox"/> Kidney Stone Assessment <input type="checkbox"/> Other:	
RADIOLOGY	
<input type="checkbox"/> CXR: PA & LAT	
<input type="checkbox"/> KUB <input type="checkbox"/> IVP	
<input type="checkbox"/> Spine: ___ Cervical ___ Thoracic ___ Lumbar	
<input type="checkbox"/> Skull <input type="checkbox"/> Sinus <input type="checkbox"/> Ribs <input type="checkbox"/> Pelvis	
<input type="checkbox"/> Other:	

MRI	
<input type="checkbox"/> With <input type="checkbox"/> Without <input type="checkbox"/> With & Without Contrast	
<input type="checkbox"/> 1.5T Open Delray <input type="checkbox"/> 1.5T Boynton <input type="checkbox"/> 3T Wellington	
<input type="checkbox"/> Valium	
<input type="checkbox"/> Brain <input type="checkbox"/> Orbit/Face/Sinus	
<input type="checkbox"/> Pituitary <input type="checkbox"/> IAC	
<input type="checkbox"/> Soft Tissue Neck	
<input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine	
<input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Compression w/Axial Load	
<input type="checkbox"/> Brachial Plexus <input type="checkbox"/> Breast	
<input type="checkbox"/> Abdomen: <input type="checkbox"/> Kidney <input type="checkbox"/> Adrenal <input type="checkbox"/> MRCP	
<input type="checkbox"/> Pelvis	
<input type="checkbox"/> Shoulder R / L <input type="checkbox"/> Elbow R / L	
<input type="checkbox"/> Wrist R / L <input type="checkbox"/> Finger/Hand R / L	
<input type="checkbox"/> Hip R / L <input type="checkbox"/> Thigh R / L	
<input type="checkbox"/> Knee R / L <input type="checkbox"/> Calf R / L	
<input type="checkbox"/> Ankle/Mid/Hindfoot R / L	
<input type="checkbox"/> Mid/Forefoot R / L	
<input type="checkbox"/> Forefoot/Toes R / L	
<input type="checkbox"/> Other:	
MR ANGIOGRAPHY	
<input type="checkbox"/> 1.5T Open Delray <input type="checkbox"/> 1.5T Boynton <input type="checkbox"/> 3T Wellington	
<input type="checkbox"/> Head: <input type="checkbox"/> Arterial <input type="checkbox"/> Venous	
<input type="checkbox"/> Neck	
<input type="checkbox"/> Chest: <input type="checkbox"/> Pulmonary <input type="checkbox"/> Aorta	
<input type="checkbox"/> Abdomen: <input type="checkbox"/> Aorta <input type="checkbox"/> Renal	
<input type="checkbox"/> Mesenteric <input type="checkbox"/> Venous	
<input type="checkbox"/> Extremity Runoff	
<input type="checkbox"/> Other:	
NUCLEAR: Delray & Boynton	
<input type="checkbox"/> Cardiac Stress Test: ___ Adeno ___ Treadmill	
<input type="checkbox"/> Bone Scan <input type="checkbox"/> Three Phase	
<input type="checkbox"/> Thyroid Uptake & Scan <input type="checkbox"/> I-131WB	
<input type="checkbox"/> Thyroid Therapy _____ mCi	
<input type="checkbox"/> Renal Scan: _____ Captopril _____ Lasix	
<input type="checkbox"/> Hida: _____ CCK	
<input type="checkbox"/> Gastric Emptying <input type="checkbox"/> Parathyroid	
<input type="checkbox"/> MUGA <input type="checkbox"/> Gallium	
<input type="checkbox"/> Brain SPECT	
<input type="checkbox"/> Liver Spleen	
<input type="checkbox"/> Liver SPECT	
<input type="checkbox"/> Other:	

PET: Boynton & Wellington	
Indication: ___ Diagnosis ___ Staging ___ Restaging	
<input type="checkbox"/> Molecular PET/CT: Boynton	
<input type="checkbox"/> PET: Wellington	
<input type="checkbox"/> Brain: Dementia/Alzheimer's	
<input type="checkbox"/> Brain: DOPA Parkinson's	
<input type="checkbox"/> Limited PET Only: Attention _____	
<input type="checkbox"/> Whole Body PET/CT Attenuation Only	
<input type="checkbox"/> Whole Body PET Diagnostic CT: Chest/Abd/Pelvis	
<input type="checkbox"/> NaF-18 PET Bone Scan	
<input type="checkbox"/> Other:	
ULTRASOUND	
<input type="checkbox"/> Abdomen: ___ Complete ___ Limited	
<input type="checkbox"/> Pelvis <input type="checkbox"/> Transvaginal	
<input type="checkbox"/> OB Complete <input type="checkbox"/> TV <12 Weeks	
<input type="checkbox"/> ABD >12 Weeks	
<input type="checkbox"/> OB with Biophysical Profile	
<input type="checkbox"/> Carotid <input type="checkbox"/> Aorta	
<input type="checkbox"/> Thyroid <input type="checkbox"/> Renal	
<input type="checkbox"/> Bladder <input type="checkbox"/> Scrotum/Testicles	
<input type="checkbox"/> Venous: Leg R / L Both	
Arm R / L Both	
<input type="checkbox"/> Arterial: Leg R / L Both	
Arm R / L Both	
<input type="checkbox"/> Echocardiogram	
<input type="checkbox"/> Other:	
BONE DENSITY	
<input type="checkbox"/> Bone Densitometry	
WOMEN'S IMAGING	
<input type="checkbox"/> Screening Digital Mammography:	
___ Bilateral ___ Unilateral ___ Implants	
<input type="checkbox"/> Diagnostic Digital Mammography:	
___ Bilateral ___ Unilateral ___ Implants	
<input type="checkbox"/> Breast Ultrasound: ___ Right ___ Left	
<input type="checkbox"/> Breast MRI	
<input type="checkbox"/> Breast MRI w/o Contrast (Implant Rupture)	
<input type="checkbox"/> Bone Density/DEXA	
<input type="checkbox"/> Transvaginal Ultrasound	
<input type="checkbox"/> Pelvis Ultrasound	
<input type="checkbox"/> OB Complete: <input type="checkbox"/> TV <12 Weeks <input type="checkbox"/> ABD >12 Weeks	
<input type="checkbox"/> OB with Biophysical Profile	
<input type="checkbox"/> Other:	