



PLEASE SELECT LOCATION

Rancho Cucamonga ♥
11088 Elm Avenue
Rancho Cucamonga, CA 91730

Montclair
9655 Monte Vista Ave., Suite 403
Montclair, CA 91763

Telephone (909) 625-2000 • Fax (909) 625-2099

Patient's Name: _____ Patient's Tel.#: _____
 Appointment Date: _____ Appointment Time: _____
 Chief Diagnosis: _____

- STAT**
- Films**
- CD**
- Report**
- Internet/Web**

MRI

HEAD

Brain
 Pituitary
 Orbits
 Sinuses
 IAC
 TMJ

EXTREMITIES/JOINTS

<input type="checkbox"/> Shoulder	<input type="checkbox"/> Right	<input type="checkbox"/> Left
<input type="checkbox"/> Knee	<input type="checkbox"/> Right	<input type="checkbox"/> Left
<input type="checkbox"/> Wrist	<input type="checkbox"/> Right	<input type="checkbox"/> Left
<input type="checkbox"/> Hip	<input type="checkbox"/> Right	<input type="checkbox"/> Left
<input type="checkbox"/> Elbow	<input type="checkbox"/> Right	<input type="checkbox"/> Left
<input type="checkbox"/> Hand	<input type="checkbox"/> Right	<input type="checkbox"/> Left
<input type="checkbox"/> Ankle	<input type="checkbox"/> Right	<input type="checkbox"/> Left
<input type="checkbox"/> Foot	<input type="checkbox"/> Right	<input type="checkbox"/> Left

SPINE

<input type="checkbox"/> Cervical	<input type="checkbox"/> Neck
<input type="checkbox"/> Thoracic	<input type="checkbox"/> Chest
<input type="checkbox"/> Lumbar	<input type="checkbox"/> Abdomen
<input type="checkbox"/> Sacrum/Coccyx	<input type="checkbox"/> Pelvis

ARTHROGRAM

<input type="checkbox"/> Shoulder	<input type="checkbox"/> Right	<input type="checkbox"/> Left
<input type="checkbox"/> Elbow	<input type="checkbox"/> Right	<input type="checkbox"/> Left
<input type="checkbox"/> Wrist	<input type="checkbox"/> Right	<input type="checkbox"/> Left
<input type="checkbox"/> Hip	<input type="checkbox"/> Right	<input type="checkbox"/> Left
<input type="checkbox"/> Knee	<input type="checkbox"/> Right	<input type="checkbox"/> Left
<input type="checkbox"/> Ankle	<input type="checkbox"/> Right	<input type="checkbox"/> Left

ANGIOGRAPHY

<input type="checkbox"/> Carotids	<input type="checkbox"/> Lower extremities
<input type="checkbox"/> Circle of Willis/Cerebral	<input type="checkbox"/> Arterial study/runoff
<input type="checkbox"/> Renal/Abdomen	<input type="checkbox"/> Cerebral venogram
<input type="checkbox"/> Other _____	

CONTRAST

Yes No

CT

Brain
 Temporal Bone
 Orbits
 Sinuses
 Nasopharynx
 TMJ
 Neck

Chest
 Abdomen
 Pelvis
 Cervical
 Thoracic
 Lumbar
 Other: _____

♥ **ANGIOGRAPHY** (64 Slice CT available only at Rancho Cucamonga)

Brain/Circle of Willis
 Carotids
 Pulmonary Arteries / Embolism
 Chest / Aorta
 Abdomen, Pelvis/Mesenteric arteries
 Renal
 Runoff (Lower Extremity)
 Other: _____

DENTAL CT

Mandible Maxilla
 Dental stents Yes No

♥ **CARDIAC CT** (64 Slice CT available only at Rancho Cucamonga)

Indication
 Does your patient have or do you suspect any of the following (Check all that apply):

<input type="checkbox"/> Chest pain	<input type="checkbox"/> CHF
<input type="checkbox"/> Cardiomegaly	<input type="checkbox"/> SOB
<input type="checkbox"/> Abnormal EKG	<input type="checkbox"/> Atherosclerosis
<input type="checkbox"/> Abnormal Echocardiogram	<input type="checkbox"/> Aortic dissection
<input type="checkbox"/> Abnormal lipid	<input type="checkbox"/> Diabetes

Study

Coronary Calcium Score (without contrast)
 CT chest/ Coronary Angiography (with contrast)

CONTRAST

Yes No

ULTRASOUND

<input type="checkbox"/> Abdomen-General	<input type="checkbox"/> Echo-Cardiogram
<input type="checkbox"/> OB	<input type="checkbox"/> Carotid Duplex
<input type="checkbox"/> Breast (L,R, Both)	<input type="checkbox"/> Vascular-Arterial
<input type="checkbox"/> Thyroid	<input type="checkbox"/> Location _____
<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Vascular-Venous
<input type="checkbox"/> Renal	<input type="checkbox"/> Location _____
<input type="checkbox"/> Pelvic	<input type="checkbox"/> Scrotum/Testis
(Trans-abdominal and Endo-vaginal)	<input type="checkbox"/> Others _____

HEALTH SCREENING

CT Whole Body Scan Contrast Yes No

Coronary Calcium Score

BONE DENSITY _____

SPECIAL INSTRUCTIONS / NOTES:

Physician's Signature: _____ **Phone #** _____

MILLENNIUM IMAGING



MRCP (Callbladder): No food or drink four (4) hours prior to the exam.

MRI Other: No prep needed.

Patients with a pacemaker, An Artificial Heart Valve, Aneurysm Clips, Permanent (tattoo) eye-liner, defibrillator, cochlear implant, pain pump, neurological stimulator or metal fragments in the eyes may not have an MRI. Please discuss with a scheduler if you have any questions.

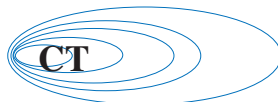


Abdomen: No food or drink four (4) hours prior to the exam.

Pelvis & OB 1st Trimester: Drink 32oz. of water thirty (30) minutes before the exam and do not urinate.

Breast: Please bring mammogram films to appointment.

Renal/Carotid/Vascular Extremities: Be well hydrated by drinking plenty of fluids, i.e., an extra 2-3 glasses of water the day of the exam.



Brain, Chest, Spine, Soft Tissue Neck, Renal Stone and Extremities:

w/o (without) Contrast: No prep needed.

w/o (without) & w/ (with) Contrast: Nothing to eat or drink four (4) hours prior to the exam.

Abdomen, Pelvis:

- w/o (without) & w/ (with) Contrast:*
1. Light dinner (no dairy products or oily foods) with nothing to eat after 9:00 p.m.
 2. Drink one (1) full bottle of oral contrast before bed.
 3. One (1) hour before the exam, drink half of the second bottle.
 4. Thirty (30) minutes before the exam, finish the remainder of the second bottle.

Cardiac CT Coronary Angiography:

No food or drink four (4) hours prior to the exam.

No consumption of alcohol, caffeine, or nicotine products on the day of the exam.

No exercise on the day of the exam.

Patients must have no contraindications to the administration of beta blockers

Patients need to discontinue the following medications 48hrs prior to Coronary CT Angiogram scan:

- Viagra
- Cialis
- Levitra
- Similar medications

2 locations serving our community



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