



**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.*

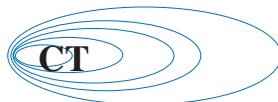


**Abdomen:** No food or drink four (4) hours prior to the exam.

**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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