9990 Dallas Parkway
Suite 110
Frisco, TX 75033

CLEAR CHOICE IMAGING

Phone: 469-887-4624
Fax: 469-782-3795

Patient Information ☐ **STAT** **Today's date: ___/___/_____**

Patient Name:________________________________ Date of Birth:__________________ Phone:__________________

Clinical Indication/ICD-10:____

Referring Physician Information

Referring Physician:______________________________ Signature (Required):________________________________

Phone:_________________________________ Fax:____

Please fax the following with referral form

Most recent clinical notes	Insurance card (front and back)	Contrast patients ONLY
Previous imaging reports	Physical therapy notes	BUN/Creatinine results that are within 30 days

MRI

☐ Without Contrast ☐ With/Without Contrast ☐ Radiologist Discretion

NEURO
- ☐ Brain
- ☐ Orbits
- ☐ IAC's
- ☐ Pituitary
- ☐ Soft Tissue Neck
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine
- ☐ Sacrum/Coccyx

BODY
- ☐ Abdomen
- ☐ TMJ
- ☐ Brachial Plexus
- ☐ Chest
- ☐ Pelvis

MRA
- ☐ Head
- ☐ Neck
- ☐ MR Venography:__________

ORTHO

Right Left Bilat
- ☐ Clavicle
- ☐ Shoulder
- ☐ Humerus
- ☐ Elbow
- ☐ Forearm
- ☐ Wrist
- ☐ Hand
- ☐ Finger(s):______________
- ☐ MSK Pelvis
- ☐ Hip
- ☐ Femur
- ☐ Knee
- ☐ Tib/Fib
- ☐ Hindfoot/Ankle
- ☐ Forefoot
- ☐ Toe(s):_________________
- ☐ Other:__________________

CT

☐ Without Contrast ☐ With Contrast ☐ With/Without Contrast
☐ Oral Contrast Only ☐ Radiologist Discretion

NEURO
- ☐ Brain
- ☐ Cervical Spine
- ☐ Lumbar Spine
- ☐ Thoracic Spine

ENT
- ☐ Maxillofacial Bones
- ☐ Soft Tissue Neck
- ☐ Orbit, Sella, Ear
- ☐ Sinus
  - Complete
  - Limited

BODY
- ☐ Abdomen
- ☐ Pelvis
- ☐ Calcium Scoring
- ☐ Chest
- ☐ Clavicle
- ☐ Lung Screening

ORTHO

Right Left Bilat
- ☐ Elbow
- ☐ Forearm
- ☐ Finger(s):_________
- ☐ Hand
- ☐ Humerus
- ☐ Shoulder
- ☐ Wrist
- ☐ Ankle
- ☐ Foot
- ☐ Calcaneus
- ☐ Femur
- ☐ Hip
- ☐ Knee
- ☐ Tib/Fib
- ☐ Toe(s):____________
- ☐ Other:____________

Ultrasound

Any study may require doppler evaluation at discretion of radiologist

- ☐ AAA
- ☐ Abdomen
  - Complete
  - Limited
- ☐ Pelvic
  - Transvaginal (if indicated)
- ☐ Testicular (includes doppler)
- ☐ OB 1st Trimester
  - Transvaginal (if indicated)
- ☐ Venous Doppler U.E. R L Bilat
- ☐ Venous Doppler L.E. R L Bilat
- ☐ Other:_____________________
- ☐ Neck-Soft Tissue
- ☐ Aortic
- ☐ Bladder Limited
- ☐ Carotid Doppler
- ☐ Retroperitoneal
- ☐ Renal
- ☐ Thyroid

X-Ray

☐ Chest	1 View	2 View		
☐ Abdomen	KUB	2 View		3 View
☐ Sinuses				
☐ Pelvis				
☐ Ribs	R	L	Bilat	
☐ Hip	R	L	Bilat	
☐ Knee	R	L	Bilat	
☐ Ankle	R	L	Bilat	
☐ Foot	R	L	Bilat	
☐ Shoulder	R	L	Bilat	
☐ Elbow	R	L	Bilat	
☐ Wrist	R	L	Bilat	
☐ Hand	R	L	Bilat	
☐ Spine	C	T	L	
○ Flex/Ext				
☐ Other:___________________________________				