



MCA Arlington Campus  
 3301 Matlock Road To Schedule: (817) 472-4857  
 Arlington, TX 76015 To Fax Orders: (469) 713-8222

MCA Mansfield Outpatient Center  
 1670 E. Broad St. Suite 104 Phone: (817) 473-3901  
 Mansfield, TX 76063 Fax: (817) 473-3970

Patient Name \_\_\_\_\_

Physician Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Age \_\_\_\_\_

Sex \_\_\_\_\_

Physician Phone # \_\_\_\_\_

MCA-Arlington

MCA-Mansfield OP

Physician Fax # \_\_\_\_\_

<b>CT</b>	<b>RAD</b>	<b>MRI-Arl.Campus only</b>	<b>NM-Arl.Campus only</b>
<input type="checkbox"/> Head/Bra <input type="checkbox"/> Sinuses <input type="checkbox"/> Facial <input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> C-spine <input type="checkbox"/> T-spine <input type="checkbox"/> L-spine <input type="checkbox"/> Kidneys/IVP <input type="checkbox"/> VirtualColonography <input type="checkbox"/> Upper Extremity <input type="checkbox"/> Lower Extremity Other _____	<input type="checkbox"/> Acute Abdomen Series <input type="checkbox"/> Abdomen <input type="checkbox"/> Chest <input type="checkbox"/> AP <input type="checkbox"/> LAT <input type="checkbox"/> Clavicle <input type="checkbox"/> Elbow <u>Views</u> <input type="checkbox"/> Femur U-2 <input type="checkbox"/> Finger <input type="checkbox"/> 3 <input type="checkbox"/> Forearm <input type="checkbox"/> 5 <input type="checkbox"/> Foot <input type="checkbox"/> Hand <input type="checkbox"/> Hip <input type="checkbox"/> Ribs <input type="checkbox"/> Humerus <input type="checkbox"/> Knee <input type="checkbox"/> Shoulder <input type="checkbox"/> C-Spine <input type="checkbox"/> L-Spine <input type="checkbox"/> T-Spine <input type="checkbox"/> Ankle Complete <input type="checkbox"/> Tibia Fibula <input type="checkbox"/> Pelvis <input type="checkbox"/> Nasal Bones <input type="checkbox"/> Sinuses Complete <input type="checkbox"/> Scappula Complete <input type="checkbox"/> Coccyx <input type="checkbox"/> AP <input type="checkbox"/> LAT <input type="checkbox"/> Sacrum <input type="checkbox"/> AP <input type="checkbox"/> LAT <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral Specify/Other _____	<input type="checkbox"/> Head/Brain <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Orbit <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Breast <input type="checkbox"/> C-Spine <input type="checkbox"/> L-Spine <input type="checkbox"/> T-Spine <input type="checkbox"/> Pelvis/Hips <input type="checkbox"/> Upper Extremity <input type="checkbox"/> Lower Extremity Other _____ <hr/> <b>MRA-Arl. Campus only</b> <input type="checkbox"/> Head/Brain <input type="checkbox"/> Chest <input type="checkbox"/> Neck <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Upper Extremity <input type="checkbox"/> Lower Extremity <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <b>CONTRAST</b> <input type="checkbox"/> wo <input type="checkbox"/> w <input type="checkbox"/> w/wo Specify _____	<input type="checkbox"/> GI Bleed <input type="checkbox"/> Cisternogram <input type="checkbox"/> Bone Scan* <input type="checkbox"/> Gallium <input type="checkbox"/> Indium* <input type="checkbox"/> Ceretec* <input type="checkbox"/> Muga <input type="checkbox"/> Cardiolite Stress* <input type="checkbox"/> Cardiolite 2Day* <input type="checkbox"/> Lung Scan V/Q <input type="checkbox"/> RenalScan* <input type="checkbox"/> Renal Scan W/Lasix <input type="checkbox"/> Renal Scan W/Cap <input type="checkbox"/> Hida Scan* <input type="checkbox"/> Hida W/Eject Frac <input type="checkbox"/> Hida W/Kinevac <input type="checkbox"/> Thyroid Scan/Uptake <input type="checkbox"/> Parathyroid Scan <input type="checkbox"/> Thyroid Suppression <input type="checkbox"/> Lymphoscintigraphy <hr/> <input type="checkbox"/> 1-131 Whole Body Specify _____ <hr/> <p style="text-align: center;">us</p> <input type="checkbox"/> Pregnancy <input type="checkbox"/> Thyroid <input type="checkbox"/> Gallbladder <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvic <input type="checkbox"/> Transvaginal <input type="checkbox"/> Breast <input type="checkbox"/> Duplex Ext Venous <input type="checkbox"/> Dopler Carotid <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral Specify/Other _____
<b>CTA</b>	<b>FLUROSCOPY-Arl. only</b>		
<input type="checkbox"/> Head/Brain <input type="checkbox"/> Neck/Carotids <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Upper Extremity <input type="checkbox"/> Lower Extremity <input type="checkbox"/> Aorta with Run-Off Specify _____	<input type="checkbox"/> Arthrogram <input type="checkbox"/> Esophagram <input type="checkbox"/> Upper GI <input type="checkbox"/> Barium Enema <input type="checkbox"/> VCUG <input type="checkbox"/> Small Bowel Series <input type="checkbox"/> Myelogram <input type="checkbox"/> Lap Band Fill		
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <b>CONTRAST</b> <input type="checkbox"/> wo <input type="checkbox"/> w <input type="checkbox"/> w/wo			
<b>LAB*</b>			
<input type="checkbox"/> BUN <input type="checkbox"/> CREAT Other _____ *Patients with Contrast age 55 and above			

Date \_\_\_\_\_ Diagnosis \_\_\_\_\_

Comment \_\_\_\_\_ Physician Signature \_\_\_\_\_ Date/Time \_\_\_\_\_

**\*POS\***

\*POS\*

DO1311 10/09