

# PROHEALTH

Advanced Imaging

www.prohealthscan.com

7345 Medical Center Dr., Ste 130, West Hills, CA 91307

P. 818.710.6011 • F. 818.710.6311

10767 Riverside Dr., North Hollywood, CA 91602

P. 818.301.6700 • F. 818.301.6701

145 South Doheny Dr., Beverly Hills, CA. 90211

P. 310.550.5858 • F. 310.550.5775



UNIVERSITY IMAGING CENTERS

www.uicscan.com

14915 Burbank Blvd., Sherman Oaks, CA 91411

P. 818.909.7111 • F. 818.909.6767

18388 Clark St., Suite 115, Tarzana, CA 91356

P. 818.609.0911 • F. 818.609.0229

5620 Wilbur Ave., Suite 330, Tarzana, CA 91356

P. 818.345.3285 • F. 818.345.5964 (XRAY ONLY)



Appointment Date & Time: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician Name: \_\_\_\_\_ Additional Report To: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Signature: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Images: ☐ None ☐ CD ☐ Film ☐ Web Access

STAT REPORT: ☐ Phone ☐ Fax ☐ Web Access

Workers Comp Only:

Assigned ☐ AME ☐ QME

## EXAM REQUEST

☐ MRI WITH 3D IMAGE RENDERING

AREA to be covered \_\_\_\_\_

ADD ☐ IV Contrast ☐ Intra-articular  
☐ at Radiologist's Discretion ☐ Oral Sedation  
☐ 1.5T Open MRI ☐ Eovist Contrast

☐ MR ANGIOGRAM (MRA) WITH 3D IMAGE RENDERING

AREA to be covered \_\_\_\_\_

ADD ☐ IV Contrast

☐ MR CHOLANGIOGRAM (MRCP) WITH 3D IMAGE RENDERING

☐ ULTRASOUND with Duplex Doppler

AREA to be covered \_\_\_\_\_

☐ No Doppler

☐ CT WITH 3D IMAGE RENDERING

AREA to be covered \_\_\_\_\_

ADD ☐ IV Contrast ☐ Oral Contrast ☐ Intra-articular  
☐ at Radiologist's Discretion ☐ Medtronic

BUN/Creatinine level \_\_\_\_\_

☐ Perform in-house CRE test at time of exam.

☐ CT ANGIOGRAM (CTA) WITH 3D IMAGE RENDERING

AREA to be covered \_\_\_\_\_

ADD ☐ IV Contrast

☐ XRAY

AREA to be covered \_\_\_\_\_

☐ DENTAL SCAN ☐ Mandible ☐ Maxilla

☐ BODY SCREEN

☐ Cardiac Screen ☐ Low Dose Lung Screen  
☐ CT Full Body Scan ☐ MRI Full Body Scan

## SPECIAL INSTRUCTIONS

Prohealth to Assist with Authorization Yes ☐ No ☐ Authorization Number: \_\_\_\_\_ Expires: \_\_\_\_\_

If YES, please complete Clinical notes below.

REQUIRED CLINICAL INFORMATION - PLEASE INCLUDE AS MUCH APPLICABLE INFORMATION FROM THE PATIENT'S CLINICAL NOTES

DIAGNOSIS: \_\_\_\_\_

And R/O \_\_\_\_\_ Date of Onset: \_\_\_\_\_

HAS THE PATIENT RECEIVED THE FOLLOWING CONSERVATIVE TREATMENT?

Physical Therapy ☐ Yes ☐ No How Long? ☐ 3 Weeks ☐ 6 Weeks ☐ 8 Weeks Was the treatment effective? ☐ Yes ☐ No

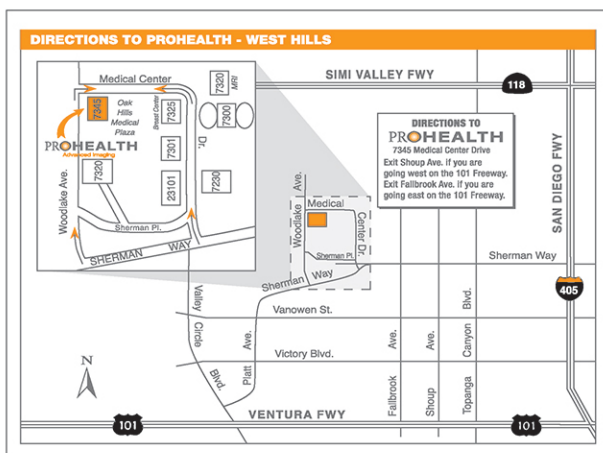
Prescribed Medication: ☐ Yes ☐ No Type: \_\_\_\_\_

Was the medication effective? ☐ Yes ☐ No

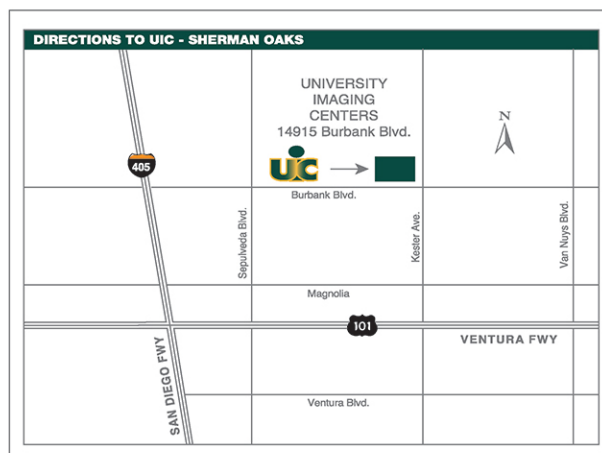
Has the Patient seen a Specialist? ☐ Yes ☐ No Is this study for a Pre-Operative Evaluation? ☐ Yes ☐ No

Previous Imaging: ☐ X-Ray ☐ CT ☐ Ultrasound ☐ MRI ☐ PET RESULTS: ☐ Abnormal ☐ Normal

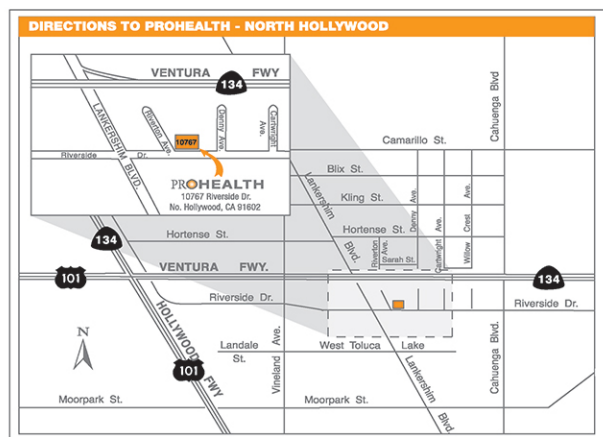
LOCATIONS & INSTRUCTIONS on the reverse



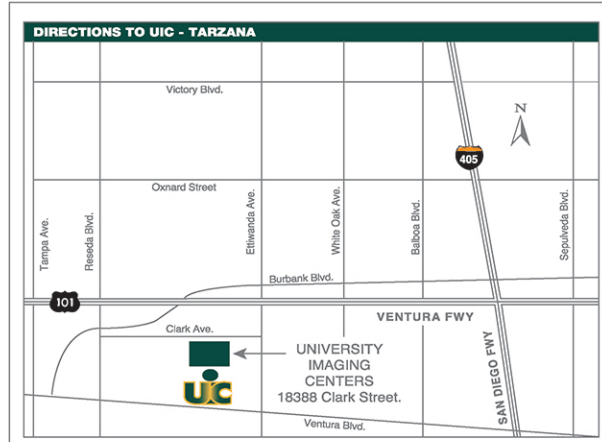
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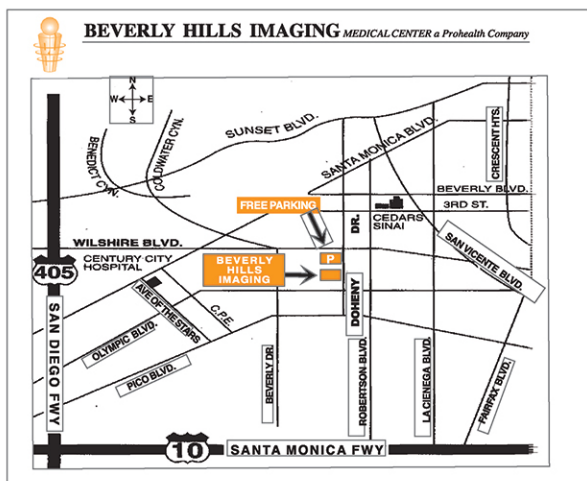
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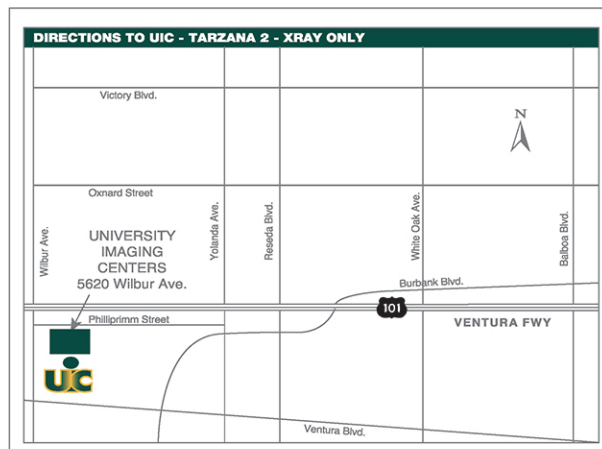
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## INSTRUCTIONS

1. Wear comfortable, loose clothing without metal zippers, snaps or trims and please leave valuables at home.
2. Please plan to arrive a minimum of 15 minutes before your appointment time and sign in at the reception area.
3. You CANNOT have an MRI if you have a cardiac pacemaker, intracranial aneurysm clip or metal fragments in your eyes or if you weigh more than 550 pounds.
4. Please call the office a day before your scheduled appointment for special instructions and exam preparations.
5. If you think you might be claustrophobic, please call us in advance for special instructions.
6. Please bring an insurance card, a photo identification and this script on the day of your appointment. Pre-registration forms are also available on our website.

**\*FREE Parking Available.**