

JEREMY N. WIERSIG M.D., P.A.

18802 Meisner Drive | San Antonio, Texas 78258  
 TEL 210 572 2222 | FAX 210 249 2177  
 www.concordimaging.com  
 OFF E. SONTERRA BLVD

**Underlined Exams Usually Require Appointments**  
**EXAMS REQUIRING SPECIAL PREPARATIONS & MAP ON BACK**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Appt. Date: \_\_\_\_\_ Appt. Time: \_\_\_\_\_

SS# \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Addl. Referring Physicians: \_\_\_\_\_

Diagnosis/Clinical History: \_\_\_\_\_

Follow Up Doctor Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

Previous Films & Location: \_\_\_\_\_

FAX REPORT (ROUTINE)

**SPECIAL REPORTING INSTRUCTIONS:**

- Films with Report to Office  CD W/ Report
- Patient to Hand Carry  Films  CD
- Fax STAT Report: \_\_\_\_\_
- Call Report:  to Office \_\_\_\_\_
- to MD \_\_\_\_\_

**MRI**

- W/O Contrast  W/ & W/O Contrast
- Per Radiologist  Intra-articular Gadolinium (Joint)

**NEURO**

- Post Fossa  C-Spine  Orbits
- Brain  Pituitary/Sella  T-Spine  TMJ
- Brain with IAC's  IAC's  L-Spine  Neck (Soft Tissue)

**BODY**

- Abdomen▲  Pelvis (Soft Tissue)▲  Prostate
- Chest  Pelvis▲  Liver▲  MRCP▲
- LEFT  RIGHT  BILATERAL
- Breast-Tumor  Wrist  Knee
- Breast-Implant  Hand/Finger  Ankle
- Shoulder  Hip w/Limited Pelv  Foot
- Elbow  Hip  Extremity\_\_\_\_\_

**CT**

- CONTRAST:  Per Radiologist  IV  W/O & W/ IV
- Oral & IV  No IV  No Oral
  - Oral ONLY

Serum Creatinine \_\_\_\_\_ Date \_\_\_\_\_  
 (Required if >50 years or diabetic)

- Brain  Neck Soft Tissue  Renal (WO/W IV)▲
- Sinuses (Coronal)  Abdomen/Pelvis▲,\*  C-Spine w/Recon
- Sinuses (Axial & Coronal)  Abdomen Only▲,\*  T-Spine w/Recon
- Pelvis Only▲,\*  L-Spine w/Recon
- Facial Bones  Chest  Extremity w/ Reconstruction\_\_\_\_\_
- Temporal Bones  Pulmonary Embolism (PE)▲  \_\_\_\_\_
- Orbits  Chest w/Upper Abd.▲,\*  \_\_\_\_\_
- \_\_\_\_\_  Chest/Abd./Pelvis▲,\*  LT  RT
- \_\_\_\_\_  Stone Protocol▲
- \_\_\_\_\_  CT IVP/Urography▲

**MR/CT ANGIOGRAPHY**

- MR Angiography  CT Angiography
- Intracranial Arteries (Head)  Chest CT - P.E.▲
- Extracranial Arteries (Neck)  Renal Arteries
- Dural Sinuses & Veins (Head)  Femoral Arteries & Runoff
- Portal Vein - Inf. Vena Cava  Mesenteric Arteries
- Aorta - Thoracic  Extremity\_\_\_\_\_
- Aorta - Abdominal  LT  RT

**PET CT**

- Skull Base to Mid-Thigh with CT Fusion\*
  - Brain with CT Fusion\*  Whole Body (Melanoma) with CT Fusion\*
- See CT section to order a diagnostic CT study

**NUCLEAR MEDICINE** (with plain films if needed)

- Bone Scan  Gastric Emptying  W/ Liquid  W/ Solid
- Total Body  W/ Reglan if Indicated
- Limited  Gallium Scan
- 3 Phase  Indium Scan
- Multi Area  Lung Scan - Vent/Perfusion
- SPECT  Shunt Evaluation
- Liver SPECT  Quantitative Evaluation
- Liver/Spleen Scan  I-131 Whole Body Scan■
- RBC Liver Hemangioma  Thyroid Uptake & Scan■
- Hepatobiliary (HIDA)■  Thyroid Scan Only\*
- W/ CCK  W/O CCK  Parathyroid Scan
- Cardiac MUGA Scan  Renal Scan\*
- Meckels Scan▲  W/ Lasix Washout
- GI Bleed  W/ Captopril
- Sentinel Node Localization

**ULTRASOUND**

- Abdomen■  Right Upper Quadrant■  Complete OB♦
- Abdominal Aorta■  Thyroid  Follow-up OB♦
- Breast  Kidney - Bilat.■  Fetal Biophysical Profile\*
- LT  RT  LT  RT  Hysterosonography\*
- Extremity  Pelvic♦  Testicular
- LT  RT (w/ Trans-vaginal if Indicated)  Axillary
- Gallbladder■  Pelvic
- Liver■ (w/ Trans-vaginal Only)
- Biopsy\*  Cyst Aspiration\*
- Fine Needle Aspiration\*

**VASCULAR ULTRASOUND**

- Arterial  Venous
- Carotid  Hepatic■
- Doppler Aorta■  Renal■
- Upper Extremity  LT  RT  Mesenteric■
- Lower Extremity  LT  RT  Portal Vein■
- Dialysis Graft Evaluation  Pseudo Aneurysm
- Abdominal Doppler\*

**BONE DENSITY STUDY (DEXA)**

- Osteoporosis Scan  Lateral Vertebral Assessment\*  Body Composition

**DIGITAL MAMMOGRAPHY/ BREAST DIAGNOSTICS**

- Previous Mammogram: \_\_\_\_\_ When \_\_\_\_\_
- Where \_\_\_\_\_
- Screening Mammogram (no symptoms) - w/ return work-up and/ or Ultrasound if indicated
  - Diagnostic Mammogram (with Ultrasound if indicated)
  - Implant Mammogram (with Ultrasound if indicated)
  - Unilateral Mammogram  LT  RT  Galactography (with Ultrasound if indicated)
  - Breast Ultrasound  LT  RT  Sentinel Node Localization
  - Fine Needle Aspiration
  - Cyst Aspiration
  - Needle Localization
  - Ultrasound/Guided Core Biopsy\*

**SPECIAL PROCEDURES**

- Joint Injection\_\_\_\_\_  Biopsy\*\_\_\_\_\_
- Arthrogram  Cervical  Thoracic  Lumbar
- Lumbar Puncture▲  Myelogram▲
- Venogram\_\_\_\_\_

**RADIOGRAPHY** (No Appointment Necessary)

- |  |  |   |
|--|--|---|
| <b>HEAD</b>  | <b>CHEST</b>   | <b>PELVIS</b>                                 |
| <input type="checkbox"/> Skull   | <input type="checkbox"/> PA & Lateral  | <input type="checkbox"/> AP                   |
| <input type="checkbox"/> Facial Bones  | <input type="checkbox"/> CXR-I View  | <input type="checkbox"/> Pelvis W/ Hips       |
| <input type="checkbox"/> Mandible  | <input type="checkbox"/> Ribs <input type="checkbox"/> LT <input type="checkbox"/> RT <input type="checkbox"/> BIL | <b>FLUOROSCOPY</b>                            |
| <input type="checkbox"/> Sinuses (Paranasal)   | <input type="checkbox"/> Sternum   | <input type="checkbox"/> Barium Swallow■      |
| <input type="checkbox"/> Waters View   | <b>ABDOMEN</b>   | <input type="checkbox"/> Upper GI■            |
| <input type="checkbox"/> Nasal Bones   | <input type="checkbox"/> KUB   | <input type="checkbox"/> Small Bowel■         |
| <input type="checkbox"/> TMJ   | <input type="checkbox"/> Flat/Upright  | <input type="checkbox"/> Barium Enema*        |
| <b>SPINE</b>   |  | <input type="checkbox"/> W/ Air Contrast      |
| <input type="checkbox"/> Thoracic Spine  |  | Other_____                                    |
| <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Lumbar Spine  |  | <input type="checkbox"/> IVP*                 |
| <input type="checkbox"/> 5 Views <input type="checkbox"/> 3 Views  |  | Serum Creatinine_____                         |
| <input type="checkbox"/> AP & Lateral Only   |  | Date_____                                     |
| <input type="checkbox"/> Davis Series (7 Views)  |  | (Required if >50 years or diabetic)           |
| <input type="checkbox"/> Flexion & Extension Only  |  | <input type="checkbox"/> VCUG                 |
| <input type="checkbox"/> Scoliosis Study   |  | <input type="checkbox"/> Cystogram            |
| <input type="checkbox"/> Sacrum/Coccyx   |  | <input type="checkbox"/> Hysterosalpingogram* |
| <input type="checkbox"/> SI Joints   |  | Other_____                                    |
| <input type="checkbox"/> Metastatic/Skeletal Survey  |  |   |
| <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/> BILATERAL  |  |   |
| <input type="checkbox"/> Shoulder <input type="checkbox"/> Finger  | <input type="checkbox"/> Calcaneus (Heel)  |   |
| <input type="checkbox"/> A/C Joints  | Specify_____   | <input type="checkbox"/> Toe                  |
| <input type="checkbox"/> Clavicle <input type="checkbox"/> Hip   | Specify_____   |   |
| <input type="checkbox"/> Scapula <input type="checkbox"/> Femur  |  |   |
| <input type="checkbox"/> Humerus <input type="checkbox"/> Knee <input type="checkbox"/> 2V <input type="checkbox"/> 3V <input type="checkbox"/> 4V <input type="checkbox"/> 5V |  |   |
| <input type="checkbox"/> Elbow <input type="checkbox"/> Tibia/Fibula   |  |   |
| <input type="checkbox"/> Forearm <input type="checkbox"/> Ankle  |  |   |
| <input type="checkbox"/> Wrist <input type="checkbox"/> Bone Age   | <input type="checkbox"/> Foot  |   |
| <input type="checkbox"/> Hand  | Other/Special Instructions_____  |   |

**SPECIAL INSTRUCTIONS:**

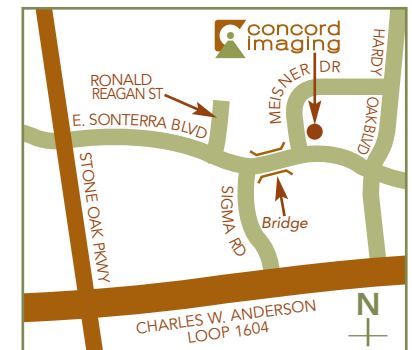
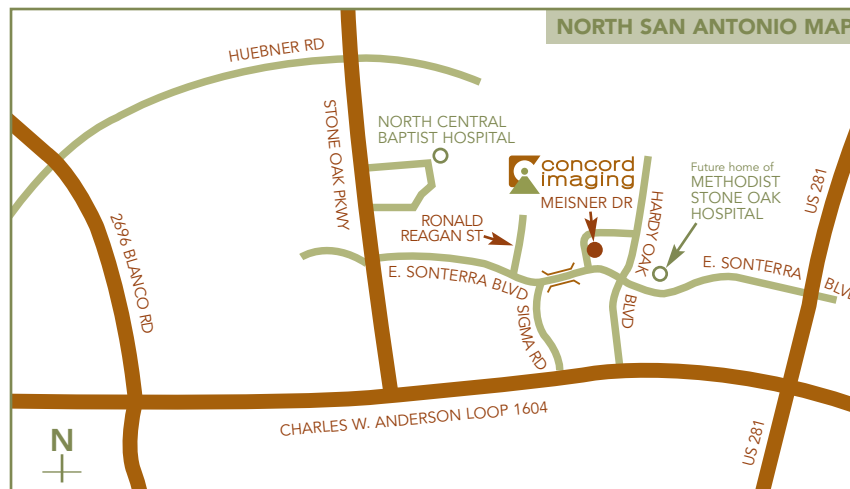
## EXAM PREPARATIONS

These preparations must be followed completely to ensure accurate test results. For the preparations for other procedures, please call our office.

### SYMBOL PREPARATION

- Nothing to eat, drink, chew or smoke after midnight.
  - ▲ Nothing to eat, drink, chew or smoke 4 hours prior to exam.
  - ◆ Drink 32oz. of water 1 hour prior to exam (DO NOT VOID).
  - \* Special preparation required, call our office.
- ☐ **CT SCAN:** Please inform the scheduler if you are taking Glucophage, Glucovance, Metformin, Avandamet, or Metaglip. Nothing to eat or drink for 3 to 4 hours prior to exam time, (except for CT sinus). We will be calling you to ask you important questions regarding your medical history. Patients receiving oral contrast may experience diarrhea.
- ☐ **CT SCAN (abdomen):** If you have not picked up your oral contrast prior to exam, please arrive 1 hour early to receive the contrast agents for your exam.
  - ☐ **CT SCAN (abdomen and pelvis):** If you have not picked up your oral contrast prior to exam, please arrive 2 ½ hours early to receive the contrast agents for your exam.
- ☐ **MAGNETIC RESONANCE IMAGING (MRI/MRA):** We will be calling you to ask you important questions regarding your medical history. \*Do not wear jewelry, hairpins, and barrettes for this exam.

### FREE CITY-WIDE TRANSPORTATION AVAILABLE FOR PATIENTS UNDERGOING CT, MRI, AND PET EXAMS



concord  imaging

18802 Meisner Drive San Antonio, TX 78258  
 TEL 210 572 2222 FAX 210 249 2177  
[www.concordimaging.com](http://www.concordimaging.com)