

ACADIANA IMAGING CENTER

MRI – CT – MYELOGRAM/FLUOROSCOPY – X-RAY - PET

501 West St. Mary Blvd., Suite 108 • Lafayette, LA 70506 • St. Francis Medical Building
 2311 Kaliste Saloom Rd. • Lafayette, LA 70508
 Office: (337) 231-5775 • Fax: (337) 231-5776

Pt. Name _____ Date/Time of Test: _____

Ordering Doctor: _____ Physician Signature: _____

Comments: _____

MRI	
MRI Brain	_____ w/wo
MRI Soft Tissue Neck	_____ w/wo
IAC's	_____ w/wo
Pituitary	_____ w/wo
MRI Orbit	_____ w/wo
MRI Cervical	_____ w/wo
MRI Thoracic	_____ w/wo
MRI Lumbar	_____ w/wo
MRI Abdomen	_____ w/wo
MRI Pelvis	_____ w/wo
MRI Lower Extremity (Area)	_____ w/wo
MRI Upper Extremity (Area)	_____ w/wo
MRI Other _____	_____ w/wo

MRA	
MRA Brain	
MRA Neck	
MRV Brain	
MRA Other	

MYELOGRAM	
Cervical Myelogram & CT	
Thoracic Myelogram & CT	
Lumbar Myelogram & CT	

X-RAY	
X-Ray Orbit	
X-Ray Sinus	
X-Ray Neck - Soft Tissue	
X-Ray Chest PA/LAT	
X-Ray Ribs - unilateral, Bilateral	
X-Ray Cervical spine 3V, 5V, 7V	
X-Ray Thoracic spine	
X-Ray Lumbar 3V, 5V, 7V	
X-Ray Abdomen Flat and Erect	
X-Ray spine 1V	
X-Ray Other (Specify)	

CT	
CT Head/Brain	_____ w/wo
CT Soft Tissue Neck	_____ w/wo
CT Chest	_____ w/wo
CT Abdomen	_____ w/wo
CT Pelvis	_____ w/wo
CT Temporal Bone	_____ w/wo
CT Sinus	_____ w/wo
CT Extremity (specify)	_____ w/wo
CT Cervical Spine	_____ w/wo
CT Thoracic Spine	_____ w/wo
CT Lumbar Spine	_____ w/wo
CT Other	

*If your patient has had surgery on the area being scanned or a history of cancer, please notify us.

Is this a WCF _____ Auto Accident _____ Attorney _____

Who is responsible for payment? _____ DOA _____

Contact Person _____ Phone # _____ Claim # _____

**PATIENTS' PREVIOUS TEST FILMS ARE NECESSARY FOR COMPARISON TO GET THE MOST ACCURATE RESULTS.