New Hope Care, LLC
US Medical Imaging Center
3840 Peachtree Industrial Blvd.
Suite 100
Duluth, GA 30096
Tel: 770-670-6565/Fax: 770-670-6566

PATIENT'S NAME: _____ DATE: _____

DATE OF BIRTH: _____ SEX: _____

PHONE: _____ EMAIL: _____

PLEASE (√) EXAM(S) REQUESTED

CT SCANS
- ☐ CT ORBITS
- ☐ CT HEAD WO
- ☐ CT HEAD WO/W
- ☐ CT SINUSES WO
- ☐ CT SINUSES W
- ☐ CT NECK W
- ☐ CT NECK WO/W
- ☐ CT CHEST WO
- ☐ CT CHEST W
- ☐ CT ABD WO
- ☐ CT ABD W
- ☐ CT PELVIS WO
- ☐ CT PELVIS W
- ☐ CT RENAL STONE PANEL
- ☐ CT BONY PELVIS
- ☐ CT UPPER EXT R L
  SITE _____
- ☐ CT LOWER EXT R L
  SITE _____
- ☐ CT CSPINE
- ☐ CT LUMBAR
- ☐ CT TSPINE
  SPECIFY LEVELS _____

ULTRASOUND
- ☐ ABDOMEN
- ☐ PELVIS COMPLETE
  - ☐ TV ONLY
  - ☐ TA ONLY
- ☐ RENAL
- ☐ GALLBLADDER
- ☐ TESTICULAR
- ☐ THYROID
- ☐ VENOUS DOPP R L
  - ☐ UPPER EXT
  - ☐ LOWER EXT
- ☐ ARTERIAL DOPP R L
  - ☐ UPPER EXT
  - ☐ LOWER EXT
- ☐ ABDOMINAL AORTA
- ☐ ECHOCARDIOGRAM
- ☐ CAROTID

CHEST
- ☐ CHEST (PA&LAT)
- ☐ CHEST (PA ONLY)
- ☐ RIBS UNILATERAL
  - ○ Incl PA CHEST
- ☐ RIBS BILATERAL
  - ○ Incl PA CHEST
- ☐ STERNUM

HEADWORK
- ☐ SKULL (AP&LAT)
- ☐ SKULL ROUTINE
- ☐ SINUS WATER'S VIEW
- ☐ FACIAL BONES
- ☐ NASAL BONES
- ☐ ORBITS

UPPER EXTREMITIES
- ☐ FINGERS
- ☐ HANDS
- ☐ WRIST
- ☐ FOREARM
- ☐ ELBOW
- ☐ HUMERUS
- ☐ SHOULDER
- ☐ CLAVICLE
- ☐ BONE AGE

SPECIFY R OR L

LOWER EXTREMITIES
- ☐ TOES
- ☐ FOOT
- ☐ ANKLE
- ☐ TIB/FIB
- ☐ KNEE
- ☐ DISTAL FEMUR
- ☐ PELVIS
- ☐ HIP UNI
- ☐ HIPS BILATERAL

SPECIFY R OR L

VERTEBRAL COLUMN
- ☐ CSPINE SINGLE VIEW
- ☐ CSPINE (AP&LAT)
- ☐ CSPINE W/ OBLIQUES
- ☐ CSPINE W/ FLEX/EXT
- ☐ TSPINE
- ☐ LUMBAR (AP&LAT)
- ☐ LUMBAR W/ OBLIQUES
- ☐ LUMBAR W/FLEX/EXT
- ☐ SACRUM/COCCYX

- ☐ BONE DENSITROMETRY

PHYSICIAN'S COMMENTS:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

PHYSICIAN'S NAME (print): _____

☐ STAT CALL: _____

☐ FAX REPORT: _____

PHYSICIAN'S SIGNATURE: _____ PH: _____ DATE: _____