

Fax this form and any screening/consent forms to 441-232-0042 or scan and email to: [imaging@hmc.bm](mailto:imaging@hmc.bm)

Physical Address: 10/12 Burnaby Street, City of Hamilton HM11 Bermuda

Patient Name \_\_\_\_\_ DOB (DD/MM/YYYY) \_\_\_\_\_ Date \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Email \_\_\_\_\_

Ordering physician \_\_\_\_\_ Copy To: \_\_\_\_\_ Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_ Cert # \_\_\_\_\_ Diagnosis & ICD10 \_\_\_\_\_

History & Symptoms: \_\_\_\_\_

**MRI Date & Value of Last Creatinine** (must be within 90 days of scan)

\_\_\_\_\_

Brain  
 Neck  
 Chest  
 Abdomen  
 Pancreas  
 Liver  
 Prostate  
 Pelvis  
 IAM's  
 IAC's  
 TMJ  
 Orbits  
 Sinuses  
 Other \_\_\_\_\_

**MR Spine**

Cervical  
 Thoracic  
 Lumbar

**MR Musculoskeletal R L**

Shoulder  
 Elbow  
 Wrist  
 Hand  
 Finger Digit 1, 2, 3, 4, 5 ?  
 Hip  
 Knee  
 Ankle  
 Foot  
 Other \_\_\_\_\_

**MR Angiogram**

Brain  
 Neck  
 Thoracic  
 Abdomen  
 Renal  
 Upper Ext. R L  
 Lower Ext. w/ Run-off R L  
 Other \_\_\_\_\_

**CT Scan Date and value of last Creatinine** (must be within 90 days of scan)

\_\_\_\_\_

Brain  
 Orbits  
 Sinuses  
 Nasal Bones  
 Facial Bones  
 Soft Tissue Neck  
 Chest  
 Abdomen  
 Pelvis  
 Abdo/Pelvis  
 Chest/Abdo/Pelvis

**CT Spine**

Cervical  
 Thoracic  
 Lumbar  
 Sacral  
 Other \_\_\_\_\_

**CT Angiography**

Head  
 Neck  
 Chest  
 Abdomen  
 Aorta (Run -off)  
 Upper Extremity R L  
 Lower Extremity R L with Run-Off  
 Other \_\_\_\_\_

**PROCEDURE INSTRUCTIONS**

**MRI** - Avoid wearing jewelry or hairpins

**MRI & CT** - All Patients need a current creatine level. Ask your doctor or HMC if you need to fast before your procedure.

**Ultrasound - Abdomen** - nothing to eat or drink from 8 hours prior. **Obstetric or Pelvic** - Drink 32 ounces of water 1 hour prior and do not empty your bladder.

**Mammography** - Wear a 2-piece outfit. Do not wear powder, lotion or deodorant near the breast area.

**Bone Densitometry** - No vitamins or supplement for 24 hours prior

**X-Ray**

Immigration Chest (PA only)  
 Chest AP/PA/Lateral  
 Abdomen Supine  
 Abdomen Supine & Upright  
 Pelvis  
 Ribs R L  
 Sternum  
 Clavicle R L  
 Sternoclavicular Joints  
 AC Joints

**Xray Spine**

Cervical  
 Thoracic  
 Lumbar  
 Sacrum/Coccyx

**Xray Extremities**

Upper Limb R L  
 Shoulder  
 Scapula  
 Humerus  
 Elbow  
 Forearm  
 Wrist  
 Hand  
 Fingers digit 1 2 3 4 5?

**Lower Limb R L**

Femur  
 Hip  
 Knee  
 Tibia/Fibula  
 Ankle  
 Heel  
 Foot  
 Toe digit 1 2 3 4 5 ?  
 Other \_\_\_\_\_

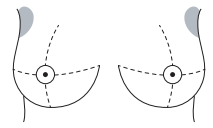
**Ultrasound Imaging**

Abdomen Complete  
 Abdomen Limited  
 Aorta  
 Thyroid  
 Breast R L  
 Retroperitoneal (Kidney, Ureter, Bladder)  
 Bladder  
 Bladder Prostate Transabdominal  
 Prostate Transrectal  
 Pelvic Transabdominal  
 Pelvic Transvaginal  
 Groin (hernia?)  
 Scrotum  
 Soft Tissue \_\_\_\_\_  
 OB Dating  
 OB T1, T2, T3  
 Other \_\_\_\_\_

**Vascular**

Carotid Doppler  
 Renal Arterial Doppler  
 Aortic Doppler  
 Venous Doppler Upper/ Lower/ R L

**Mammography**



Mammogram Screening 2D/3D  
 Mammogram Diagnostic R L 2D/3D

**Bone Densitometry**

Bone Density (DXA)  
 Body Composition Study

**Cardiology**

ECG  
 Exercise ECG  
 24 hr Blood Pressure monitor