

SCHEDULING INFORMATION
1300 S Bryan Rd., Ste 104
Mission, TX 78572
Tel. 956-583-0004
Tel. 956-585-8700
Fax 956-583-5790

Baaxten

Imaging Center

SAME DAY APPOINTMENT

APPOINTMENT DATE _____

APPOINTMENT TIME _____ AM/PM

(Stat 2hrs upon request only)

(See Map on the back)
 (Vea el mapa al reverso)

Please arrive on time or 15 min. before your appointment.
 If you arrive late Baaxten Imaging Center will have to reschedule your appointment.

Patient Name _____ Patient Phone _____ DOB _____

Insurance _____ Insurance ID # _____ Group # _____

Call patient to schedule appt? yes no Phone # _____ Pre Cert # _____ Group/IND NPI _____

Referring MD _____ Phone: _____ Fax: _____

CLINICAL INFORMATION (please specify signs/symptoms)

Referring Physician Signature (required) _____ DX: 1. _____ 2. _____

Give patient CD Comparison Study **Required** **Mandatory (ICD 10)**

OPEN MRI

- | | | |
|------------------------------------|--|---|
| <input type="checkbox"/> Left | <input type="checkbox"/> WITHOUT IV CONTRAST | <input type="checkbox"/> WITHOUT AND WITH IV CONTRAST |
| <input type="checkbox"/> Right | <input type="checkbox"/> Head/Brain | <input type="checkbox"/> Pituitary |
| <input type="checkbox"/> Bilateral | <input type="checkbox"/> L-Spine | <input type="checkbox"/> T-Spine |
| | <input type="checkbox"/> Knee | <input type="checkbox"/> Ankle |
| | <input type="checkbox"/> Extremity _____ | <input type="checkbox"/> Orbits Neck (Soft Tissue) |
| | | <input type="checkbox"/> Hip |
| | | <input type="checkbox"/> Foot |
| | | <input type="checkbox"/> Other _____ |
| | | <input type="checkbox"/> IAC'S |
| | | <input type="checkbox"/> Pelvis (Boney Structure) |
| | | <input type="checkbox"/> Shoulder |
| | | <input type="checkbox"/> C-Spine |
| | | <input type="checkbox"/> Wrist |
| | | <input type="checkbox"/> Elbow |

CT

CT Angiography

- | | | |
|------------------------------------|--|--|
| <input type="checkbox"/> Left | <input type="checkbox"/> WITHOUT IV CONTRAST | <input type="checkbox"/> WITHOUT AND WITH IV CONTRAST |
| <input type="checkbox"/> Right | <input type="checkbox"/> Head/Brain | <input type="checkbox"/> Abdomen/Pelvis |
| <input type="checkbox"/> Bilateral | <input type="checkbox"/> CTA Head (COW) | <input type="checkbox"/> CTA Aorta-Abdominal |
| | <input type="checkbox"/> Chest | <input type="checkbox"/> CTA Portal Vein inf Vena Cava |
| | <input type="checkbox"/> Chest CTA PE* | <input type="checkbox"/> Pelvic |
| | <input type="checkbox"/> CTA Aorta-Thoracic | <input type="checkbox"/> Abdomen |
| | <input type="checkbox"/> 3D | <input type="checkbox"/> Extremity _____ |
| | | <input type="checkbox"/> Other _____ |
| | | <input type="checkbox"/> CTA Renal Arteries |
| | | <input type="checkbox"/> Renal Protocolo |
| | | <input type="checkbox"/> CT Urogram |
| | | <input type="checkbox"/> Neck Soft Tissue |
| | | <input type="checkbox"/> CTA Carotids |
| | | <input type="checkbox"/> CTA Femoral Arteries & Runoff |
| | | <input type="checkbox"/> Mesentric Arteries |
| | | <input type="checkbox"/> C-Spine |
| | | <input type="checkbox"/> T-Spine |
| | | <input type="checkbox"/> L-Spine |
| | | <input type="checkbox"/> Ribs 3D |

* PE: result within 1 hour

WOMEN'S IMAGING

- | | | | |
|------------------------------------|--|---|--|
| <input type="checkbox"/> Left | <input type="checkbox"/> Digital Screening Mammogram | <input type="checkbox"/> Digital Diagnostic Mammogram | <input type="checkbox"/> Diagnostic Ultrasound |
| <input type="checkbox"/> Right | | | |
| <input type="checkbox"/> Bilateral | | | |

NOTE: Please make sure patient brings previous Mammo study before or the day of appt.

GENERAL

- | | | | | | |
|------------------------------------|---------------------------------------|--|---------------------------------|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Left | <input type="checkbox"/> Abdomen | <input type="checkbox"/> ABD-Lmtd | <input type="checkbox"/> Pelvic | <input type="checkbox"/> Renal | <input type="checkbox"/> Testicular |
| <input type="checkbox"/> Right | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Aorta | <input type="checkbox"/> Neck | <input type="checkbox"/> Soft Tissue | <input type="checkbox"/> Breast |
| <input type="checkbox"/> Bilateral | <input type="checkbox"/> Transvaginal | <input type="checkbox"/> Breast (Diagnostic) | | <input type="checkbox"/> Other _____ | |

VASCULAR/

- | | | | | | |
|----------------------------------|--|---|------------------------------|-----------------------------|-----------------------------|
| <input type="checkbox"/> Echo | <input type="checkbox"/> Renal Artery | <input type="checkbox"/> Arterial Lower | <input type="checkbox"/> Bil | <input type="checkbox"/> RT | <input type="checkbox"/> LT |
| <input type="checkbox"/> Carotid | <input type="checkbox"/> AAA (Abdominal Aorta) | <input type="checkbox"/> ABI Upper | <input type="checkbox"/> Bil | <input type="checkbox"/> RT | <input type="checkbox"/> LT |
| | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Venous Lower | <input type="checkbox"/> Bil | <input type="checkbox"/> RT | <input type="checkbox"/> LT |
| | | <input type="checkbox"/> Venous Upper | <input type="checkbox"/> Bil | <input type="checkbox"/> RT | <input type="checkbox"/> LT |

BONE DENSITY STUDY (DEXA)

- Osteoporosis Scan Lateral Vertebral Assessment* Body Composition

X-RAY

- | | | | | | | | |
|--------------------------------------|--------------------------------------|--|---------------------------------------|-----------------------------------|---|----------------------------------|----------------------------------|
| <input type="checkbox"/> Left | <input type="checkbox"/> C-Spine | <input type="checkbox"/> T-Spine | <input type="checkbox"/> L-Spine | <input type="checkbox"/> Pelvis | <input type="checkbox"/> Hip | <input type="checkbox"/> Femur | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Right | <input type="checkbox"/> TIB/FIB | <input type="checkbox"/> Ankle | <input type="checkbox"/> Foot | <input type="checkbox"/> Clavicle | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Humerus | <input type="checkbox"/> Elbow |
| <input type="checkbox"/> Bilateral | <input type="checkbox"/> Forearm | <input type="checkbox"/> Wrist | <input type="checkbox"/> Hand | <input type="checkbox"/> Finger | <input type="checkbox"/> Toe | <input type="checkbox"/> Sternum | <input type="checkbox"/> Skull |
| <input type="checkbox"/> W/Flex/Ext. | <input type="checkbox"/> Nasal Bones | <input type="checkbox"/> Paranasal Sinuses | <input type="checkbox"/> Facial Bones | <input type="checkbox"/> Mandible | <input type="checkbox"/> Chest PA & LAT | <input type="checkbox"/> Ribs | <input type="checkbox"/> Abdomen |
| | <input type="checkbox"/> KUB | <input type="checkbox"/> Coccyx/Sacrum | <input type="checkbox"/> TMJ's | <input type="checkbox"/> IVP | <input type="checkbox"/> Other: _____ | | |

PATIENT PREPARATION INSTRUCTIONS

Please follow preps carefully to insure an accurate exam. Diabetic patients should not take insulin if fasting is required. Photo identification is required for your exam.

DIGITAL MAMMOGRAPHY

DO NOT apply any powders, deodorant, ointments to the underarm area or breast area on the day of the exam. If you experience breast tenderness prior to or during menstruation, try to schedule a routine mammogram at a more comfortable time during your cycle. Wear a two-piece outfit.

ULTRASOUND

GALL BLADDER OR ABDOMEN: Patient should be fasting for eight (8) hours prior to the exam. Nothing to eat, drink or chew gum.

TRANS/ABD., PELVIS AND PREGNANCY (UP TO 6 MONTHS): 1½ hours before exam, go to the bathroom, then drink 32oz. (four 4) 8oz. glasses) of liquid. All fluids must be completed 1 hour before appointment. DO NOT use the bathroom until after the ultrasound has been completed.

ULTRASOUND RENAL: Drink 16oz of water 30 min. prior to exam

CT SCAN

CHEST, HEAD, NECK, EXTREMITIES, SINUSES, AND SPINE: No preparation necessary. **ABDOMEN / PELVIS:** NPO (nothing to eat or drink) after midnight.

*You will be given a drink as part of the exam and will need to wait one hour prior to scanning.

*If you are allergic to iodine please inform technologist before drinking contrast.

EXAMS ORDERED WITH IV CONTRAST: NPO after midnight.

*If you are allergic to iodine please inform the technologist.

*Diabetics or patients over 50 years of age must have a BUN and creatinine lab test at least 72 hours prior to day of exam in order to avoid delays in scan time or rescheduling.

*If you are taking diabetic medication containing metformin you will need to stop taking your medication after your exam for 48 hours (two days).

*If you have any concern or questions about stopping your medication, please consult with your physician.

TODDLERS: Ages 36 months to 6 years: Sleep deprive patient on midnight the day before exam. Do not let child sleep at any time prior to arriving.

OPEN MRI

CONTRAINDICATIONS: If you have the following devices implanted in your body you will not be able to have an MRI exam: Pacemaker cardiac valve with metal, Cochlear implants, TENS Unit, Brain aneurysm clip or battery operated pump (Insulin, pain medications, etc...).

CLOTHING SUGGESTIONS for MRI: Do not bring jewelry of any kind. Wear comfortable loose clothing such as warm-ups. Do not wear anything with metal zippers, buttons, anything metallic will affect the image of the exam and will get attracted to the magnet. Do not wear any make up or mascara.

X-RAYS

NO preparation necessary

BONE DENSITY

*If you had a barium, CT scan, radioisotope, or if you have been injected with any contrast dye (use testing purposes) you should make the technician aware. they may require you to wait 10-14 days before your bone density procedure.

*Do not take calcium supplements for a minimum of 24 hours (1 day) before your scheduled test.

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INSTRUCCIONES DE PREPARACION PARA EL PACIENTE

Favor de seguir esta instruccines para poder obtener datso precisos en el examen. Los pacientes diabeticos NO deberan tomar insulina cuando se requiera ayuno. Se solicitara una identificacion con fotografia para poder realizar el examen

DIGITAL MAMMOGRAPHY

NO aplique ningún talco, desodorante, ungüentos al área de la axila o al área de la mama el día del examen. Si experimenta sensibilidad en los senos antes o durante la menstruación, trate de programar una mamografía de rutina en un momento más cómodo durante su ciclo. Use un traje de dos piezas.

ECOGRAFIA/ULTRASONIDO

ABDOMEN: No beba ni coma durante 6 o 8 horas antes del examen.

TIROIDES: Quite todas las joyas alrededor del cuello. Se le colocara una toalla enrollada detras del cuello durante el examen.

SENO: Si usted o su medico palpan una masa en sus senos, se le pedira que indique donde esta. El examen puede mostrar si la masa es solida o si esta llena de liquido, lo que se llama quiste.

ESCROTO O TESTICULO: Es posible que tenga que ponerse de pie para algunas imagenes. Puede que se le pida que puje como si estuviera teniendo evacuaciones intestinales.

PELVIS: Debe tomar 32 onzas o 1 litro de agua para el examen de manera que la vejiga este llena. Termine de beber el agua 1 hora antes del examen. Durante el exmane se tomarn las imagenes, Se le pedira que vaya al baño a orinar despues del examen

EXAMEN DE TOMOGRAFIA COMPUTALIZADA/CT SCAN

Por favor no ingiera alimentos solidos durante cuatro hora ante del examen.

Por favo no ingiera o beba nada durante dos horas antes del examen.

ABDOMEN: Se le dara un liquido de contraste que debera tomar antes de llegar al centro de estudio. El dia el examen, siga las instrucciones que viene en el recipiente. Cada recipiente representa una dosis.

RESONANCIA MAGNETICA (MRI)

si se tomara imagenes de su higado o pancreas, no coma ni beba nada durante 4 horas antes del exmen.

INFORME AL PERSONAL DE INMEDIATO SI : • Esta embarazada o cree que podria estarlo; • Esta amamantando; • Pesa mas de 300 libras ó 136 kilos; • Tiene un marcapasos cardiaco u o otro dispositivo implantado como bomba o estimulador de insulina, • tiene Clips para aneurismas; • Tiene Metralla o fragmentos de metal en el cuerpo; • Tiene placa o protesis articular: •Es alergico al liquido de contraste.

Quite todos los articulos que pudieran swer afectados por el iman. Estos pueden incluir horquillas para el cabello, joyas, monedas, dentadura postizas, lleves o tarjetas de credito . Deje los articulos de valor en casa. Se le pedira que se ponga una bata de hospital.

RADIOGRAFIA / RAYOS - X

NO es necesaria ninguna preparacion

DENSITOMETRIA OSEA (DEXA)

* Si se le han rayos-x con bario (series GI), una tomografia computarizada, radioisotopo, o si se le ha inyectado un colorante de contraste para algun examen, hagase lo saber al tecnico. Podrian hacerle esperar de 10 a 14 dias antes de poder realizar este procedimiento.

*No tome suplementos de calcio por al menos 24 horas antes del estudio.

*Use ropa comoda que libre de cualquier objeto de metal y que sea facil de cambiar en caso que se le pida ponerse una bata de hospital.

