

AMERICAN WELLNESS & IMAGING

524 Colorado Avenue
Santa Monica, CA 90401

IMAGING DIAGNOSTICS

Phone: 310-260-2917
Fax: 310-587-9236

Patient Name: _____ Date: _____
Home Phone: _____ Work Phone: _____
Referring MD : _____ Referring MD Signature: _____
Referring MD Phone: _____ Additional Reports to MD: _____

Diagnosis: _____
_____ **Routine** _____ **STAT** _____ **WET READ REQUESTED** via _____ **Phone** or _____ **Fax**

Caution:
For MRI exams: if the patient has a **Pacemaker, Aneurysm Clips, Implanted Electronic Devices**, or is **Pregnant** please contact the imaging center before scheduling an MRI exam.
For **CT** patients on **Metformin** please call the imaging center before scheduling your patient.

MRI - CONTRAST ___ YES ___ NO

- Brain
- Orbits
- Pituitary
- IACs/Posterior Fossa
- Soft Tissue Neck
- TMJ
- Chest
- Abdomen
- Pelvis
- Liver
- Adrenal / Kidney
- Cervical Spine
- Thoracic Spine
- Lumbar Spine
- Sacrum/Coccyx
- Sacroiliac Joints
- Shoulder R or L
- Elbow R or L
- Wrist R or L
- Hand R or L
- Humerus R or L
- Radius/Ulna R or L
- Brachial Plexus R or L
- Knee R or L
- Ankle R or L
- Foot R or L
- Femur R or L
- Tibia/Fibula R or L
- Hip R or L

(circle)

MRA

- Brain
- Cervical Carotids
- Renal
- Peripheral Vascular

MRCP

- Cholangiogram

MR Arthrography:

(circle)

- Shoulder R or L
- Knee R or L
- Ankle R or L
- Wrist R or L
- Hip R or L
- Elbow R or L

CT - CONTRAST ___ YES ___ NO

- Brain
- Orbits
- IACs/Posterior Fossa
- Sinuses
- Soft Tissue Neck
- TMJ
- Cervical Spine
- Thoracic Spine
- Lumbar Spine
- Chest
- Abdomen only
- Pelvis only
- Abdomen & Pelvis
- Bony Pelvis
- Liver
- Pancreas
- Urogram
- Extremity - Upper
- Extremity - Lower

CTA

- Brain
- Neck
- Pulmonary
- Chest
- Aorta
- Renal
- Abdomen
- Pelvic
- Iliofemoral Runoff

WELLNESS SCANS

- Total Body Scan:
 - CT Chest
 - CT Coronary Artery
 - MR Abdomen/Pelvis
- CT Lung Screening
- CT Colonography
- Coronary Calcium Scoring

Clinical Information: Please Fax Lab Results to 310-587-9236

*For IV Contrast: ALL diabetic patients, ALL patients with kidney disease and ALL patients over age 60 must have BUN / CREATININE levels done within one month prior to their CT IV Contrast Exam.

BUN _____ CREATININE _____

JOINT ASPIRATIONS

(circle)

- Shoulder R or L
- Knee R or L
- Ankle R or L
- Wrist R or L
- Hip R or L
- Elbow R or L

American Wellness & Imaging Patient Instructions

At American Wellness & Imaging we strive to make your visit as convenient and comfortable as possible. Please arrive at our center at least 20 minutes prior to your appointment time to check in and complete your paperwork. If you need to cancel your appointment, please call 310-260-2917, 24 hours in advance.

Your Appointment is Scheduled For:

DATE: _____ Time: _____

LOCATION: 524 Colorado Ave., Santa Monica, CA 90401 Phone:310-260-2917 Fax: 310-587-9236

Preparation for your Radiology Exam:

MRI

Wear clothing WITH NO METAL zippers, buttons, snaps, etc. Wear NO jewelry or makeup.

PATIENTS WITH CARDIAC PACEMAKERS CANNOT BE SCANNED.

For MRIs of the Abdomen - nothing to eat or drink for 4 hours prior to your exam.

CT SCAN

Nothing to eat or drink except clear liquids for 4 hours prior to an examination of the head, neck, chest, abdomen, or pelvis. You may continue to take any medications. If you are to ingest an oral contrast for an abdomen or pelvis CT Scan, that oral contrast is to be picked up 24 hours prior to your appointment.

PAYMENT POLICY

We participate in Medicare and most other insurance plans.

Please bring your insurance identification card with you. We may ask for payment of co-insurance and deductibles. We accept major credit cards as well as personal checks.

Authorization for Worker's Compensation and Motor Vehicle Accidents must be presented prior to exam.

Please remember our staff is here to help. If you have any questions, please don't hesitate to call.

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SLEEP DIAGNOSTICS

Phone: 310-260-2917
Fax: 310-587-9236

Today's Date: _____ Study Date: _____
Patient Name: _____ DOB: _____
Address: _____ SS#: _____
Home Phone: _____ Work Phone: _____
Referring MD: _____ Referring MD Signature: _____
Referring MD Phone: _____ Referring MD UPIN# _____
Referring MD Fax: _____ Additional Reports to MDs: _____

SLEEP STUDY ORDER

___ **Sleep Disorder Evaluation and Management**
(Clinical Assessment, Patient Education, Diagnostic PSG,
CPAP/BiPAP Titration when indicated,
Follow-Up and Management)

___ **Diagnostic Polysomnography**

___ **CPAP / BiPAP Titration Study**

___ **MSLT (normally requires PSG the night before)**

___ **Maintenance of Wakefulness**

DIAGNOSES

- ___ **Insomnia with Sleep Apnea**
- ___ **Other Sleep Insomnia**
- ___ **Disruptions of 24 Hour Sleep-Wake Cycle**
- ___ **Dysfunction Associated with Sleep Stages or Arousal from Sleep**
- ___ **Stereotyped Rep. Movements**
- ___ **Persistent Disorder of Initiating or Maintaining Wakefulness**
- ___ **Somnambulism / Night Terrors**
- ___ **Myoclonus / Restless Leg Syndrome**
- ___ **Hypersomnia with Sleep Apnea**
- ___ **Other Hypersomnia**
- ___ **Respiratory Failure**
- ___ **Repetitive Intrusions from Sleep**
- ___ **Cataplexy and Narcolepsy**

REASON FOR REFERRAL / ADDITIONAL ORDERS

(Please include pertinent history, copies of previous studies, progress notes, etc.)

ICD-9: _____ CPT CODE (S): _____

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DATE: _____ Time: _____

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Preparation for your Sleep Study:

Please feel free to stop by our center before your scheduled appointment to look over the sleep rooms and get a feeling for where we are located. Our staff will be happy to show you around.

On the day of your sleep study, please avoid caffeine (coffee, tea, cola, chocolate) after 12:00 noon and try not to nap.

Your hair should be washed and dried without hairspray, oils or gels.

Please let us know if you are taking any medications prior to your study.

The technician will greet you, show you around the lab and show you to your room. You will receive instructions on how the test will begin and what is involved in collecting a sleep study.

Once your study has ended, the results will be forwarded to the referring physician after it has been scored and interpreted by a physician.

PAYMENT POLICY

We participate in Medicare and most other insurance plans.

Please bring your insurance identification card with you. We may ask for payment of co-insurance and deductibles. We accept major credit cards as well as personal checks.

Authorization for Worker's Compensation and Motor Vehicle Accidents must be presented prior to exam.

Please remember our staff is here to help. If you have any questions, please don't hesitate to call.