



**Marietta Imaging Center**  
780 Canton Road, Suite 230  
Marietta, GA 30060

**Marietta Imaging Center  
East Cobb Open MRI**  
1197 Johnson Ferry Road  
Suite 200  
Marietta, GA 30068

**Marietta Imaging  
Centers@ North Cobb**  
4791 South Main Street  
Suite 140  
Acworth, GA 30101

Website: www.mariettaimaging.com

For Scheduling Call: (770) 792-1234

Fax: (770) 424-1194

Patient Name: _____ D.O.B. _____ Diagnosis: _____ ICD-9 Code: _____ Ordering Physician: _____ Physician Phone Number: _____ Physician Signature and Date: _____	Patient Contact Number: _____ Precert needed: <input type="checkbox"/> Yes <input type="checkbox"/> No Precert #: _____ STAT Call Report to: <input type="checkbox"/> Yes <input type="checkbox"/> No # _____ Provider after hours phone #: _____ NPI #: _____
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**Special Instructions**  Patient has been scheduled  Patient needs to be scheduled  Call Report  Send Films with Patient  Send CD with Patient

Appt. Date: \_\_\_\_\_ Arrival: \_\_\_\_\_ Appt. Time: \_\_\_\_\_

### REQUESTED TESTS (Please Circle)

<b>ABDOMEN &amp; CHEST</b> <input type="checkbox"/> Abd 1 View (KUB) <input type="checkbox"/> Abd 2 Views <input type="checkbox"/> Abd Series-F&U Chest <input type="checkbox"/> Chest - 1 View <input type="checkbox"/> Chest - 2 Views (PA & LAT) <input type="checkbox"/> Ribs - Bilateral <input type="checkbox"/> Ribs - Unilateral R L <input type="checkbox"/> Sternum <input type="checkbox"/> Other _____ <b>GI TRACT</b> <input type="checkbox"/> Barium Enema <input type="checkbox"/> Barium Enema-Air Contrast <input type="checkbox"/> Barium Swallow <input type="checkbox"/> GI Series-Air Contrast <input type="checkbox"/> Small Bowel Series <input type="checkbox"/> GI Series Air w/Sm Bowel <input type="checkbox"/> Other _____ <b>HEAD</b> <input type="checkbox"/> Facial Bones - 3 Views <input type="checkbox"/> Mandible <input type="checkbox"/> Nasal Bone <input type="checkbox"/> Sinuses <input type="checkbox"/> TMJ's <input type="checkbox"/> Skull-Limited <input type="checkbox"/> Skull-Routine <input type="checkbox"/> Waters View Only <input type="checkbox"/> Neck Soft Tissue <input type="checkbox"/> Orbits-Min 4 Views <input type="checkbox"/> Other _____ <b>SPECIALS</b> <input type="checkbox"/> Arthrogram R L <input type="checkbox"/> Myelogram _____ <input type="checkbox"/> Other _____	<b>SPINES</b> <input type="checkbox"/> Cervical Limited <input type="checkbox"/> Cervical Routine <input type="checkbox"/> Lumbar Limited <input type="checkbox"/> Lumbar Routine <input type="checkbox"/> Sacrum/Coccyx <input type="checkbox"/> Thoracic-Lumbar AP & Lat <input type="checkbox"/> Thoracic Routine <input type="checkbox"/> Other _____ <b>UPPER EXTREMITIES</b> <input type="checkbox"/> Clavicle <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Elbow AP & Lat <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Elbow Min. 3 Views <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Finger _____ <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Forearm <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Hand 2 Views <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Hand Min 3 Views <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Humerus <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Shoulder Min 2 Views <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Wrist <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Scapula <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Other _____ <b>LOWER EXTREMITIES</b> <input type="checkbox"/> Ankle Min 3 Views <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Ankle AP & Lat <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Femur <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Foot Min 3 Views <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Hip 1 View <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Hip 2 Views <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Knee AP & Lat <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Knees AP Standing <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Knee Min. 3 Views <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Leg Tib-Fib <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Patella <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Pelvis <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Toes _____ <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Other _____ <b>URINARY TRACT</b> <input type="checkbox"/> IVP	<b>MAMMOGRAMS</b> <input type="checkbox"/> Mammo Screening Bilateral / Unilateral R L <input type="checkbox"/> Mammo Diag Bilateral <input type="checkbox"/> Mammo Diag Unilateral R L <input type="checkbox"/> Add'l View Bilateral <input type="checkbox"/> Add'l View Unilateral R L <input type="checkbox"/> Diag. Mammo w/ Breast U/S (if clinically indicated) <input type="checkbox"/> Other _____ <b>CT SCANS</b> <input type="checkbox"/> Abdomen W/ Contrast <input type="checkbox"/> Abdomen W/O Contrast <input type="checkbox"/> Abdomen W & W/O Contrast <input type="checkbox"/> Cardiac Scoring CT <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Chest W/ Contrast <input type="checkbox"/> Chest W/O Contrast <input type="checkbox"/> Chest W & W/O Contrast <input type="checkbox"/> CTA _____ <input type="checkbox"/> CT Maxillofacial w/o <input type="checkbox"/> Head W/O Contrast <input type="checkbox"/> Head W&W/O Contrast <input type="checkbox"/> L-Spine <input type="checkbox"/> Lower Extremity R__ L__ <input type="checkbox"/> Orbits W/ Contrast <input type="checkbox"/> Orbits W/O Contrast <input type="checkbox"/> Pelvis W/ Contrast <input type="checkbox"/> Pelvis W/O Contrast <input type="checkbox"/> Pelvis W & W/O Contrast <input type="checkbox"/> Screening CT Sinus Contrast <input type="checkbox"/> Sinuses W/O Contrast Complete <input type="checkbox"/> Soft Tissue Neck W/O & W/O W/Contrast <input type="checkbox"/> T-Spine <input type="checkbox"/> Upper Extremity <input type="checkbox"/> Other _____ <b>BONE DENSITY</b> <input type="checkbox"/> DEXA	<b>MRI (Magnetic Resonance Imaging)</b> <input type="checkbox"/> <b>OPEN MRI</b> <input type="checkbox"/> Brain w/o contrast <input type="checkbox"/> Brain w & w/o contrast <input type="checkbox"/> Pituitary w & w/o contrast <input type="checkbox"/> IACs w & w/o contrast <input type="checkbox"/> Orbits <input type="checkbox"/> TMJs <input type="checkbox"/> Neck (soft tissues) w & w/o contrast <input type="checkbox"/> Chest <input type="checkbox"/> Pelvis (bone) <input type="checkbox"/> Abdomen _____ Liver W/O W _____ Kidneys W/O W _____ Pancreas W/O W _____ Gallbladder (MRCP) W/O W <input type="checkbox"/> Pelvis (soft tissue) <input type="checkbox"/> Cervical Spine w/o contrast <input type="checkbox"/> Cervical Spine w & w/o contrast <input type="checkbox"/> Thoracic Spine w/o contrast <input type="checkbox"/> Thoracic Spine w & w/o contrast <input type="checkbox"/> Lumbar Spine w/o contrast <input type="checkbox"/> Lumbar Spine w & w/o contrast <input type="checkbox"/> Elbow <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Wrist <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Hand <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Ankle <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Foot <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Shoulder <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Knee <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Hip <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Other _____ <input type="checkbox"/> MRA Abdomen W/O W <input type="checkbox"/> MRA Brain/COW W/O only <input type="checkbox"/> MRA Carotid w/o & with <b>Ultrasound</b> <input type="checkbox"/> Abdomen Complete <input type="checkbox"/> Abdominal Doppler <input type="checkbox"/> Aorta <input type="checkbox"/> Aorta Screening <input type="checkbox"/> Arterial Doppler R L Bilateral <input type="checkbox"/> Breast R L Bilateral <input type="checkbox"/> Carotid <input type="checkbox"/> GB / RUQ / Liver <input type="checkbox"/> Pelvic <input type="checkbox"/> Pelvic with Transvaginal (if clinically indicated) <input type="checkbox"/> OB 1st Trimester <input type="checkbox"/> OB Complete <input type="checkbox"/> OB Limited <input type="checkbox"/> PVR <input type="checkbox"/> Renal <input type="checkbox"/> Renal Doppler <input type="checkbox"/> Scrotum <input type="checkbox"/> Soft Tissue <input type="checkbox"/> Spleen <input type="checkbox"/> Thyroid <input type="checkbox"/> Venous Doppler R L Bilateral <input type="checkbox"/> Other _____
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Thank you for using Marietta Imaging Centers 770-792-1234 fax: 770-424-1194

white copy - patient - (please bring this form with you)

yellow copy - ordering physician

# PATIENT INSTRUCTIONS FOR TEST PREPARATION

## Colon and IVP Preps

### Day before the exam:

Non-residue Diet - NO SUGAR OR DAIRY PRODUCTS

### LIGHT LUNCH

(Clear soup, plain gelatin, unsweetened tea, black coffee, UNSWEETENED juices)

1:00 PM Drink 8 oz glass of water

2:00 PM Drink 8 oz glass of water

3:00 PM Drink 8 oz glass of water

4:00 PM Drink 8 oz glass of water

5:00 PM SUPPER

(Clear soup, plain gelatin, unsweetened tea, black coffee, UNSWEETENED juices)

5:30 PM DRINK BOTTLE OF MAGNESIUM CITRATE (may drink "over ice")

6:00 PM Drink 8 oz glass of water

7:00 PM Drink 8 oz glass of water

8:00 PM Drink 8 oz glass of water

9:00 PM Drink 8 oz glass of water

9:30 PM Take 4 (Four) Prep Kit Tablets With Water. Do Not Chew.

\*\*\*\*\* DO NOT HAVE ANYTHING TO eat or drink after midnight \*\*\*\*\*

### Morning of the exam:

Insert the Prep Kit Suppository approximately 45 minutes to one hour before leaving home for the exam.

You may only have sips of water if necessary for medications.

## Mammograms

Do not wear any powders, deodorants or lotions

## Upper GI

Do not eat or drink anything after midnight the night before the exam

## CT Scan WITH Contrast

Do not eat or drink anything AFTER MIDNIGHT the night before the exam

## MRI

Recent lab test for kidney function.

Pre-screening for pacemakers, aneurysm clips and foreign objects.

## Ultrasound (Abdominal, Gallbladder, Aorta and Liver)

Do not eat or drink anything EIGHT HOURS before the exam

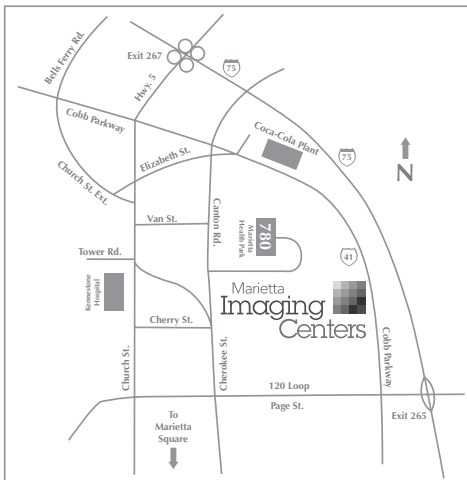
## Ultrasound (Pelvis and OB)

Drink 32 oz of non-carbonated liquids beginning one hour before the exam.

Do not urinate until after the exam is complete, as a full bladder is required.

## Ultrasound (Thyroid, Breast, Carotids, Dopplers and Kidneys)

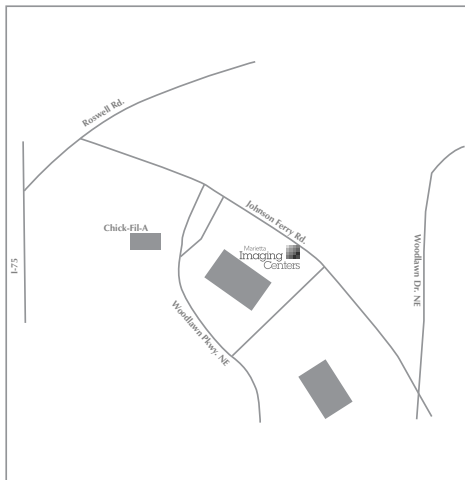
No preparation required.



Marietta Health Park  
780 Canton Road, Suite 230, Marietta, GA 30060  
I-75 N, exit 267B to Marietta, Merge onto GA-5 Spur,  
turn left on Cherry Street, left at Canton Road.

Maps not to scale.

Marietta  
Imaging  
Centers  
770-792-1234



East Cobb  
1197 Johnson Ferry Road, Suite 200, Marietta, GA 300  
I-75 N, exit 263 GA120 loop to Roswell, slight  
left to stay on GA120 loop, take ramp to GA120-  
Roswell Road, right at Johnson Ferry Road,  
right at Chick-fil-A into shopping center.



North Cobb  
4791 South Main Street, Suite 140  
Acworth, GA 30101