Las Colinas Imaging @ Tuscan

an affiliate of Las Colinas Medical Center
701 Tuscan Drive, Suite 185 • Irving, TX 75039 • (972) 969-2330
Las Colinas Scheduling Service (972) 612-6565

Please call for appointment (or to cancel) Monday - Friday 8:00 am - 4:30 pm
Please visit our Website for exam information: ***LasColinasMedical.com***

❑ Contact patient to schedule an appointment ❑ Allow Las Colinas scheduling to obtain physician Precert for procedure ❑ Please send patient clinicals for precert

Patient's Name:_____ Diagnosis/Reason: _____

Birth Date:_____ Phone: (Home)_____ Is it appropriate for the hospital to communicate with you by email? ❑ Yes ❑ No

Email address: _____

Appt. Date: _____ Time:_____ Physician: _____

Patient Social Security Number: _____ Name of Insurance Company: _____

Id# for Insurance Company: _____ Contact Number of Insurance Company: _____

Name of Insured:_____ Group ID#: _____

PLEASE ALLOW 30 MINUTES FOR REGISTRATION PROCESS. BRING THIS FORM, ALL INSURANCE CARDS, PICTURE I.D. AND ANY PREVIOUS OUTSIDE EXAMS WITH YOU. PLEASE SEE REVERSE SIDE FOR IMPORTANT PRE-PROCEDURE PREPARATIONS.

X-RAY EXAMS

____ Chest (PA & Lat)
____ Abdomen
____ Abdomen (Flat & Upright)
____ Ribs: L _____ R_____ Bilateral _____
____ Cervical Spine
____ Complete ____ AP & Lat.
____ With Flexion & Extension Views
____ Lumbosacral Spine
____ Complete ____ AP & Lat.
____ Scoliosis Series
____ Hip: L _____ R_____
____ Pelvis
____ Skull
____ Facial Bones
____ Sinuses
____ Extremity (Specify Below):
____ Ankle ____Humerus
____ Clavicle ____Knee
____ Elbow ____Leg
____ Femur ____Shoulder
____ Forearm ____Toes
____ Finger ____Wrist
L _____ R_____ Bilateral _____
____Hand
____ Other X-Ray Exam:_____
_____

ULTRASOUND

Prep: Nothing to eat or drink after midnight the night before the exam.

____ Abdominal Sono Complete
____ Abdomen Sono Limited
____ Gallbladder
____ Liver
____ Renal w/ Doppler

____ Aorta ____ Thyroid
____Carotid Study ____ Testicular
____ Venous Study
L _____ R_____ Bilateral_____
Upper_____ Lower_____
____ Renal Sono
____ Other: _____

Prep: Drink 32 oz of water within 15 min. 1 hour prior to exam. Bladder must be full.

____ Pelvic Sono (Transabdominal) with Transvaginal if indicated
____ OB Sono ❑ 1st ❑ 2nd ❑ 3rd
____ Fetal Biophysical Profile

CT SCANS

0 = without contrast 1 = with contrast 2 = Both

(If over 55 or high risk renal patient with high blood pressure or diabetes need creatinine value for any IV contrast exams)
Creatinine:_____ Date Drawn: _____
❑ Do creatinine prior to exam

All abdominal/pelvic CT exams are w/ oral contrast unless otherwise indicated.

____ CT Abdomen
____ CT Abdomen and Pelvis
____ CT Chest / Thorax
____ CT Head / Brain
____ CT Pelvis
____ CT Sinus
____ CT Spine (Specify Area):_____
_____
____ CT Urogram (for Renal Calculi)
____ CT Other (Specify Area):_____
_____

***PLEASE SEE REVERSE FOR EXAM PREPARATION**

ORDERING PHYSICIAN'S SIGNATURE: _____ DATE:_____

FAX TO: 469-484-1311

LAS COLINAS Medical Center
6800 N. MacArthur Blvd. • Irving, TX 75039
(972) 969-2000

OUTPATIENT DIAGNOSTIC TESTING PRESCRIPTION FORM

POS

PATIENT IDENTIFICATION

LCM00121 (Rev. 3/10)