SOLANO DIAGNOSTICS IMAGING
A NorthBay Affiliate

☐ STAT
☐ URGENT
☐ ROUTINE

FAIRFIELD OFFICE
1101 B. Gale Wilson Blvd., #100
1100 B. Gale Wilson Blvd., (MRI)
Fairfield, CA 94533
(707) 646-4646 *phone*
(707) **646-4949** *fax*

VACAVILLE OFFICE:
1020 Nut Tree Road #150
1002 Nut Tree Road (MRI)
Vacaville, CA 95687
(707) 646-4646 *phone*
(707) **646-4949** *fax*

DIAGNOSTIC IMAGING REFERRAL FORM

Date: _____ Patient's Name: _____ DOB: _____

Insurance: _____ Patient Phone: _____

Physician comments: _____

_____

Diagnosis Code/Reason for Exam: _____

Print Physician Name: _____ Physician Signature: _____ Phone: _____

X-RAY: *(please check and/or circle)*

❑ Chest PA & Lateral Decubitus
❑ Extremity: _____ L/R
❑ Abdomen ❑ Pelvis
❑ Spine: Cervical 3 view 5 view
Lumbar 3 view 5 view
Thoracic 2 view
❑ Other _____

CT:

❑ Chest ❑ Abdomen ❑ Pelvis
❑ Head ❑ Sinuses ❑ Soft Tissue Neck
❑ Spine - C T L ❑ CT Angio _____
❑ Extremity _____ L/R
❑ Other _____

MRI:

❑ Abdomen
❑ Brain
❑ Extremity _____ L/R
❑ Other _____

PET:

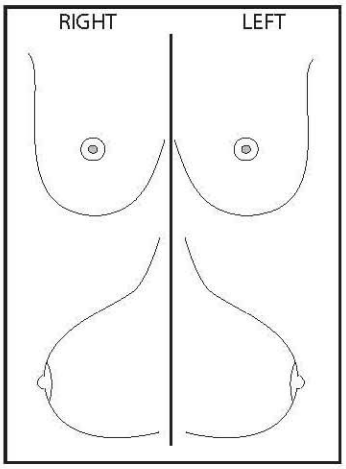
❑ Oncology - Cancer type: _____
❑ Other _____

DIGITAL MAMMOGRAM:

❑ Screening ❑ Breast Implants
(Includes 3D if indicated)
❑ Diagnostic ❑ Unil ❑ Bilat
(Includes 3D if indicated)

SPECIALTY BREAST EXAM:

❑ Ultrasound *(indicate area on drawing)*
❑ MRI Breast
❑ Breast **Biopsy**
❑ **Stereotactic**
❑ **Ultrasound Guided**
❑ **MRI Guided**



❑ DEXA SCAN

❑ Bone Density
❑ Vertebral Fracture Assessment (VFA)

ULTRASOUND:

❑ Abdominal (Attention to: _____)
❑ Renal
❑ Pelvic (w/ endovaginal)
❑ OB ..... ❑ Twins
❑ Thyroid
❑ Carotid
❑ Scrotum
❑ Soft Tissue: _____
❑ Other: _____

Please ask the patient the following question to rule out contraindications to the exam:

Is she pregnant? ❑ Yes ❑ No For MRI: Does the patient have a pacemaker or aneurysm clip(s): ❑ Yes ❑ No