BROADWAY IMAGING CENTER

140 North Glendale Avenue • Glendale, CA 91206
Tel: 818-548-0022 • Fax: 818-548-8385

Your Appointment:

Date:_____

Time:_____

Patient's Name: _____ DATE:_____

Age: _____ Pregnant Y / N _____ Allergy Y / N _____

Referred by: _____ Tel:_____ Fax:_____

CT SCAN 16 Slice

01 ☐ Abdomen
02 ☐ Head
03 ☐ Neck
04 ☐ Chest
05 ☐ Extremity (specify site)
_____
06 ☐ Pelvis
07 ☐ Sinus
08 ☐ Spine
☐ Cervical
☐ Lumbar
☐ Thoracic
08 ☐ Contrast Study Requested
09 ☐ CT Angiography (specify site)
_____

ULTRASOUND

12 ☐ Abdomen
13 ☐ Aorta
14 ☐ Bladder
15 ☐ Breast
16 ☐ Gallbladder
17 ☐ Kidneys
18 ☐ Liver
19 ☐ Obstetric
20 ☐ Pelvic
21 ☐ Soft Tissue / Muscle
22 ☐ Other

CARDIOVASCULAR

31 ☐ Arterial Imaging
☐ Carotid
☐ Lower Extremity
☐ Upper Extremity
32 ☐ Echocardiography
☐ 2D M-mode
☐ Doppler
☐ Color
33 ☐ Venous Imaging
☐ Lower Extremity
34 ☐ Other

OPEN MRI / MRA

46 ☐ Abdomen
☐ MRCP
47 ☐ Chest
48 ☐ Brain
49 ☐ Pelvis
50 ☐ Spine
☐ Cervical ☐ Lumbar
☐ Thoracic
51 ☐ Other _____
52 ☐ Contrast Study
53 ☐ MR Angiography*
54 ☐ MR Arthrography*
55 ☐ Extremity*
* Specify Site_____

MAMMOGRAPHY

10 ☐ Screening
11 ☐ Symptomatic
☐ Both
☐ Left
☐ Right

X-RAY General

23 ☐ Abdomen
24 ☐ Chest
25 ☐ Facial Bones
26 ☐ Pelvis
27 ☐ Sinuses
28 ☐ SPINE
☐ Cervical
☐ Lumbar
☐ Thoracic
29 ☐ Ribs : Specify
30 ☐ Other

X-RAY Extremities

35 ☐ Lower Extremity
36 ☐ Hip
37 ☐ Knee
38 ☐ Ankle
39 ☐ Foot
40 ☐ Upper Extremity
41 ☐ Shoulder
42 ☐ Elbow
43 ☐ Wrist
44 ☐ Hand
45 ☐ Other

X-RAY / Fluoro

56 ☐ IVP
57 ☐ Other
__ *By Appointment*
58 ☐ DEXA-SCAN
☐ Bone Density
☐ Vertebral Fracture Assessment

PHYSICIAN'S SIGNATURE: _____

CLINICAL HISTORY & REASON FOR STUDY: _____

Notes: