



Diagnostic Outpatient Imaging

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Appt. Date: _____

Call Patient to Schedule

Appt. Time: _____

Please arrive by / Llegar a las: _____

Patient Name _____ Date of Birth _____

Cell Phone _____ Phone # _____ Insurance _____

Referring Physician _____ Diagnosis _____

Report Preference: _____ Patient's next appointment with the Doctor: _____

Routine: Stat: Circle Selection(s) or Specify Preference Stat Cell # _____

Physician Signature _____ Date _____

MRI ■ Wide Bore 3T ■ 1.5T ■ Open

CONTRAST: WITHOUT WITH AND WITHOUT PER PROTOCOL

- Brain
- Brain, Seizure Protocol
- Brain, MS Protocol
- Brain & Orbits
- Brain & Pituitary
- Brain & IAC

- Spine**
- Cervical
 - Thoracic
 - Lumbar
 - Sacrum, Coccyx

- MRA- Vascular**
- MRA- Brain
 - MRA- Neck & Arch
 - MRA- Thoracic Aorta
 - MRA- Abdominal Aorta
 - MRA- Mesenteric
 - MRA- Renal
 - MRA- Pelvis
 - MRA- Runoff

- Body**
- Breast (Bilateral)
 - Chest
 - Cardiac
 - Abdomen
 - Liver MRCP
 - Pancreas
 - Pelvis
 - Prostate (PSA = _____)
 - Uterine Mapping

3T Only Exams

- Perfusion
- CSF Flow
- Diffusion Tensor Imaging
- Spectroscopy

DIGITAL X-RAY - CR

- | | | |
|---|--|---------|
| <input type="checkbox"/> Skull (4V) | <input type="checkbox"/> Shoulder (4V) | R L Bil |
| <input type="checkbox"/> Nasal (3V) | <input type="checkbox"/> Clavicle | R L Bil |
| <input type="checkbox"/> Chest (1V, 2V) | <input type="checkbox"/> Humerus (2V) | R L Bil |
| <input type="checkbox"/> Ribs R L Bil | <input type="checkbox"/> Elbow (3V) | R L Bil |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Forearm (2V) | R L Bil |
| <input type="checkbox"/> Abdomen (2V)(KUB) | <input type="checkbox"/> Wrist (3V) | R L Bil |
| <input type="checkbox"/> Cervical (3V, 5V) Flex Ext | <input type="checkbox"/> Hand (3V) | R L Bil |
| <input type="checkbox"/> Thoracic (3V) | <input type="checkbox"/> Femur (2V) | R L Bil |
| <input type="checkbox"/> Lumbar (3V, 5V) Flex Ext | <input type="checkbox"/> Knee (3V) | R L Bil |
| <input type="checkbox"/> Sacrum+Coccyx (3V) | <input type="checkbox"/> Tib/Fib (2V) | R L Bil |
| <input type="checkbox"/> SI Joints (4V) | <input type="checkbox"/> Ankle (3V) | R L Bil |
| <input type="checkbox"/> TMJ (2V) R L Bil | <input type="checkbox"/> Foot (3V) | R L Bil |
| <input type="checkbox"/> Bone Age | <input type="checkbox"/> Calcaneus (2V) | R L Bil |
| <input type="checkbox"/> Pelvis (1V) | <input type="checkbox"/> Toes (3V) | R L Bil |
| <input type="checkbox"/> Hip R L Bil | <input type="checkbox"/> Finger (3V) R L P R M I T | |
| <input type="checkbox"/> Other: _____ | | |

Diagnosis: _____

MRI Arthrogram: _____ Other: _____

Diagnosis: _____ NO PACEMAKERS

CT MULTISLICE / MULTIPLANAR / 3D

CONTRAST: WITHOUT WITH AND WITHOUT

- Brain Temporal Bone & Mastoids
- Sinus
- Spine C T L
- CT Myelogram L T C
- Kidney Stone Protocol (Abdo/Pelvis without)
- CT Urogram
- Adrenal Washout
- Pancreatic Protocol
- Liver, Hemangioma Protocol

- Chest Abdomen
- Chest for PE Pelvis
- Chest High Resolution Neck
- Parathyroid

CTA ANGIO, WITH CONTRAST

- Brain Abdomen-Pelvis
- Neck Aorta with Runoff
- Chest Renal

Other: _____

Diagnosis: _____

US ULTRASOUND

- | | | |
|--|---|---|
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Gallbladder | VASCULAR |
| <input type="checkbox"/> Renal | <input type="checkbox"/> Bladder | |
| <input type="checkbox"/> Testicular | <input type="checkbox"/> Prostate | <input type="checkbox"/> Abdo Aorta |
| <input type="checkbox"/> Pelvis - Trans vaginal unless specified | | <input type="checkbox"/> Carotid |
| <input type="checkbox"/> Breast R L | <input type="checkbox"/> Breast Biopsy | <input type="checkbox"/> Venous Doppler <input type="checkbox"/> Upper Ext. - R L <input type="checkbox"/> Lower Ext. - R L |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Thyroid Biopsy/FNA | <input type="checkbox"/> Arterial Doppler <input type="checkbox"/> Upper Ext. - R L <input type="checkbox"/> Lower Ext. - R L |
| <input type="checkbox"/> Biophysical Profile | <input type="checkbox"/> 3D/4D OB (28-32 Weeks) | |
| <input type="checkbox"/> Obstetrical <input type="checkbox"/> Early <input type="checkbox"/> Complete <input type="checkbox"/> Limited | | |

Other: _____ Diagnosis: _____

DEXA BONE DENSITOMETRY

Forearm: RT LT

Lumbar Spine:

HIP: RT LT Bilat

DIGITAL MAMMOGRAPHY

WITH COMPUTER ASSISTED DIAGNOSIS

- Bilateral Screening Mammogram (May do Ultrasound & Additional Mammographic views as indicated).
- Bilateral Screening Mammogram
- Diagnostic Bilateral Mammogram
- Unilateral Mammogram R L
- Spot Compression Mammograms R L
- Spot Mag Mammograms R L
- Other: _____

Diagnosis: _____

Bring Previous Mammograms

BIOPSY - BODY PART

(We recommend direct discussion with radiologist)

PREPARING FOR YOUR EXAM

ALL: Please wear comfortable clothing without any metal

MAGNETIC RESONANCE EXAMS (MRI):

Each exam is 30-60 minutes depending on exam.

- No special preparation necessary. It is preferred that no facial or eye make-up be worn. DO NOT wear any metal objects. Wear comfortable clothing and bring any recent x-ray films pertinent to the study.

COMPUTED TOMOGRAPHY (CT):

Clear liquids are allowed, and all prescribed medications should be taken as usual. In addition:

- Head-No solid food for 4 hours prior to exam
- Abdomen/Pelvis- Call for instructions. You may need to arrive 1 hr 30 minutes before exam time. No solid food for 8 hours prior.
- Virtual Colonoscopy-Call at least 4 days in advance to arrange to pickup the prekit.
- CT Angiography-Well hydrated the day before exam. Fasting 4 hours before.
- Myelogram-No food or drink 4 hours prior to exam.

MAMMOGRAPHY:

Do not wear antiperspirant, talcum powder, or lotion under your arms on the day of exam. Bring prior mammograms if possible or have the facilities name, address & telephone number available.

ULTRASOUND (ABDOMINAL, LIVER, GB, PANCREAS):

Nothing to eat or drink after midnight before exam (NO smoking or gum chewing before exam).

ULTRASOUND (OB & PELVIC):

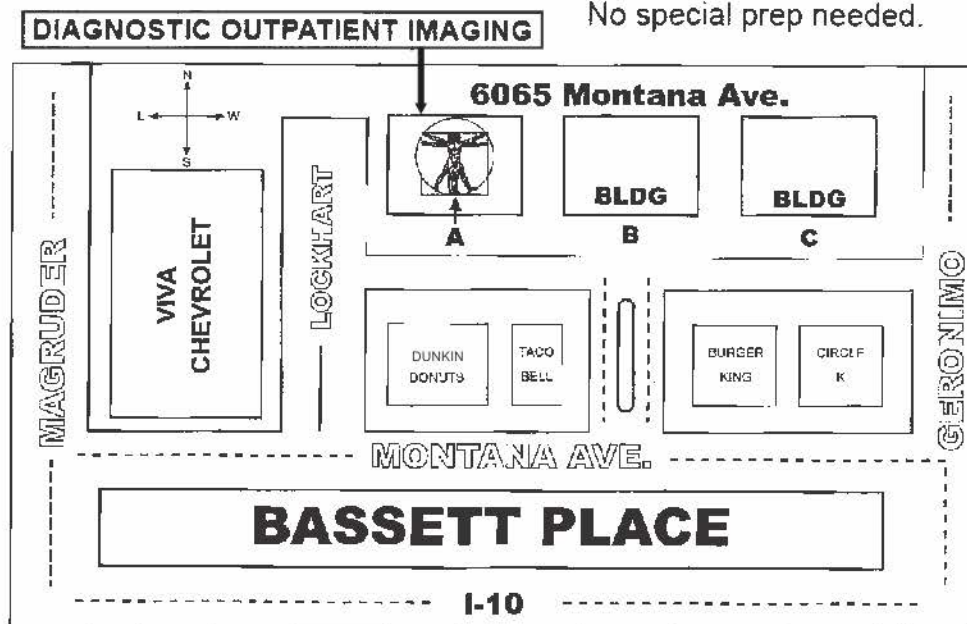
Empty your bladder one hour and a half before your scheduled appointment time, then drink five 8 oz. glasses of water within 30 minutes (four (4) glasses for OB patients). DO NOT empty your bladder, as a full bladder is necessary for this exam

BONE DENSITOMETRY:

Please do not take calcium pill the day of exam.

PLAIN FILM RADIOGRAPHY (X-RAY):

No special prep needed.



- 1) Exit 1-10 at Geronimo, turn North towards Bassett Center.
- 2) Turn left at Montana
- 3) Turn right immediately before Viva Chevrolet on Lockhart.
- 4) Diagnostic Outpatient Imaging is on your right. (Look for the man in the circle logo)