**Physician Office Instructions:** This form must be faxed to Access Center, (205) 638-4803

**PLEASE CIRCLE PREFERRED EXAM AND CHECK WHERE INDICATED.**

<table>
<thead>
<tr>
<th>MRI</th>
<th>CT</th>
<th>ULTRASOUND</th>
<th>DIAGNOSTIC X-RAY</th>
<th>FLUOROSCOPY</th>
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<tbody>
<tr>
<td>W/Sedation</td>
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<td>Abdomen Complete</td>
<td>Abdomen Limited: (Specify)</td>
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<td>W/Contrast</td>
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</table>

**DOES PATIENT HAVE:**

- Pacemaker ☐ Yes ☐ No
- Aneurysm Clip ☐ Yes ☐ No
- Claustrophobia ☐ Yes ☐ No
- Implanted mechanical or electronic devices ☐ Yes ☐ No

<table>
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<tr>
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</table>

**Diagnostic X-Ray**

- (List Specific Exam)
  - Abdomen Complete
  - Abdomen Limited: (Specify)
  - Pelvis
  - LMP:

**Fluoroscopy**

- Esophagram
- Upper GI
- UGI Small Bowel
- VCU

**Written Diagnosis and/or Reason for Test (Required):** ICD-10 code, "R/O", or "Evaluate for" are not acceptable

**Physician's/Prescriber Signature (Required):**

**Date (Required):**

**Time (Required):**

**Printed Physician's/Prescriber name (Required):**

**Office Number (Required):**

**Precertification Number (Required):**

**Precertification Expiration Date (Required):**

**Secondary Precertification Number (Required):**

**Secondary Precertification Expiration Date (Required):**

CH-09-0076 Revised 01/2017
CT SCAN

ABDOMEN, PELVIS, ANY EXAM INCLUDING CONTRAST

Nothing to eat or drink 2 hours prior to exam

If with sedation, follow instructions given on sedation letter you will receive prior to the appointment.

Be sure to tell the technologist if any of the following applies to you:

- Think you may be pregnant.

ULTRASOUND

ABDOMEN, ABDOMINAL AREA (GALLBLADDER, PANCREAS, LIVER)

Less than 6 months of age: nothing to eat or drink 2 hours prior to exam.

More than 6 months of age: nothing to eat or drink 4 hours prior to exam.

PELVIC ULTRASOUND

Patient should drink fluid 1 1/2 hours prior to exam time.

Do Not Urinate.

MRI

Follow your normal routine and continue any prescription medication, unless your doctor has told you otherwise. Do NOT wear any metal such as jewelry or hair pins. Dress comfortably.

If with sedation, follow instructions given on sedation letter you will receive prior to the appointment.

Be sure to tell the technologist if any of the following applies to you:

- Have a pacemaker.

- Metal fragments are in your body (surgical staples, cochlear implants, dental bridges, metal aneurysm clips, shrapnel, hearing aids or other metal implants).

- Think you may be pregnant.

Driving Directions to PIC:

FROM THE NORTH ON I-65
Traveling South on I-65 take Exit 250 to the right and bear left onto I-459 North (Atlanta/Gadsden).
- Take Acton Road exit 17 to the right and turn left onto Acton Road.
- Go under the interstate and at the second traffic light turn right onto Elmer J. Bissell Road.
- The building will be on the left.

FROM THE SOUTH ON I-65
Traveling North on I-65 take Exit 250 to the right and bear right onto I-459 North (Atlanta/Gadsden).
- Take Acton Road Exit 17.
- Turn left onto Acton Road.
- Go under the interstate and at the second traffic light turn right onto Elmer J. Bissell Road.
- The building will be on the left.

FROM THE EAST/WEST ON U.S. 280
Traveling on East and West 280 take the I-459 South Exit (Montgomery/Tuscaloosa), go 2 miles.
- Take Acton Road Exit 17 to the right.
- Turn right onto Acton Road and at the traffic light turn right onto Elmer J. Bissell Road.
- The building will be on the left.

FROM THE SOUTH ON I-459
Traveling North on I-459
- Take Acton Road Exit 17.
- Turn left onto Acton Road, go under the interstate and at the second traffic light turn right onto Elmer J. Bissell Road.
- The building will be on the left.

FROM THE NORTH ON I-459
Traveling South on I-459
- Take Acton Road Exit 17.
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Physician Office Instructions: This form must be faxed to Access Center, (205) 638-4803

Please circle preferred exam and check where indicated.

Appointment Date:  Appointment Time:  D.O.B.:

Patient Name:  Home Phone:  Work Phone:  Cell Phone:

Allergies:  Weight:   Height:

Special Instructions:   LMP:

- STAT Report fax to:
- Send Film/CD with patient

Written Diagnosis and/or Reason for Test (Required): ICD-10 code, "R/O", or "Evaluate for" are not acceptable

Physician's/Prescriber Signature (Required):

Date (Required):  Time (Required):

Printed Physician's/Prescriber name (Required):

Office Number (Required):

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