153 South Main Street

Newtown, Connecticut 06470

(203) 426-3002 Fax: (203) 426-6411

☐ STAT Report Requested
☐ Office Visit to follow

Ordering Physician Signature: ____________________________ Phone: ________________

Patient Name: ___________________________ Phone: ___________________

Appointment Date: _______________________Time: ___________

☐ **MRI** ☐ **Spiral CT** ☐ **Radiography** ☐ **Ultrasound**

Clinical History/ Reason for Exam (Required): ____

Magnetic Resonance Imaging

☐ Brain	☐ Pharynx/Sinuses	☐ Abdomen	☐ Knee
☐ IAC	☐ Cervical Spine	☐ Shoulder	☐ Ankle
☐ Orbits	☐ Lumbar Spine	☐ Elbow	☐ Foot
☐ Pituitary	☐ Brachial Plexus	☐ Wrist	☐ Pelvis
☐ Neck/ Parotid	☐ Lumbar Plexus	☐ Hip	

☐ Left	☐ Right
☐ Contrast	☐ Non- Contrast

Spiral CT Scanning

☐ Brain	☐ Chest	☐ Cervical Spine
☐ Sinuses	☐ Chest/High Res.	☐ Thoracic Spine
☐ Orbits	☐ Abdomen	☐ Lumbar Spine
☐ Temporal Bone	☐ Pelvis	☐ Extremity
☐ Neck(soft tissue)	☐ Stone Study	☐ Maxillofacial

☐ Left	☐ Right
☐ Contrast	☐ Non- Contrast

Ultrasound

☐ Abdomen	☐ Pelvis	☐ Thyroid	☐ Scrotum	☐ Renal
☐ Transvaginal	☐ Bladder	☐ Extremity	☐ Right Ext.	☐ Left Ext.

☐ Other: ______________________________________

Diagnostic X- Ray

☐ Chest(Pa &Lat)	☐ Abdomen	☐ Lower Extremity
☐ Ribs L / R	☐ Head/ Face	☐ Spine (C, T, or L)
☐ Ribs Bilateral	☐ Upper Extremity	

Specify: _________________________