

## PREPARATIONS FOR ALL PATIENTS

You MUST bring the following to your exam:

- Valid Government issued photo ID and Insurance Card
- Referring provider's order
- **Prior images & reports from Centrelake and outside facilities for the same region/body part are required!**

Most exams cannot be performed if you are currently pregnant. If you may be pregnant, please inform your technologist or patient care specialist.

**No unattended children** in the waiting room or the examination room. Please make arrangements for their care during your appointment.

**Co-payment will be required at time of service**

### CT Studies with IV Contrast

**TABLE WEIGHT LIMIT: 350lbs**

**IV CONTRAST EXAMS:** Please do not eat 4 hrs prior to your exam. Drink 32 oz. of water the evening prior and 32 oz. of water the morning of your exam. **Please inform us if you have any allergies, especially allergy to iodine.**

If you are receiving IV contrast AND meet any of the qualifications below, you will be required to provide recent eGFR/lab results outlined below:

- a. You are over the age of 60; or
- b. You are diabetic; or
- c. You have a history of kidney disease, transplant or nephrectomy; or
- d. You are on dialysis

We will require a recent blood test containing your estimated glomerular filtration rate (eGFR). Blood test must have been performed within 30 days from the date of your scheduled exam. Patients on dialysis must be dialyzed on the same day of injections and no later than 24 hours from the time of injection. Please coordinate with your dialysis center. Dialysis appointment confirmation is requested.

### MRI

**TABLE WEIGHT LIMIT: 350lbs (Up to 600lbs available in El Monte only)**

Please wear loose clothing for your comfort. Refrain from wearing clothing with excessive metals. **For your safety, please inform us if you have any of the following:**

- Heart pacemaker
- Pregnancy
- Stents
- Shunts (please provide ID card with specifics of shunt used)
- Metal Fragments (bullets, sheet-metal worker, etc.)
- Artificial cardiac valves (please provide ID card with specifics of valve replaced)
- Bone, joint replacement, spinal rods or metal plates
- Brain aneurysm clips (please provide ID card with specifics of surgical clips)
- Any other previous surgery
- Neuro-stimulators
- Inner ear implants
- Intrauterine devices/Stimulators

Patients having MRCP, MRI Abdomen are asked to refrain from eating 4 hours prior to your exam. **Plenty of fluids are recommended before your exam.**

For all other MRI studies, you may eat and drink normally and take your medications as usual. If your exam is in the afternoon please drink plenty of fluids.

**Note: We do not require eGFR for MRI Studies.**

### CT Abdomen/Pelvic Exams

**TABLE WEIGHT LIMIT: 350lbs**

**NON-IV CONTRAST EXAMS:** For CT Abdomen or Pelvic exams, please see the Oral Contrast Preparations below. No preparations are required for all other CT exams.

**ORAL CONTRAST PREPARATIONS:** Please do not eat 4 hrs prior to your exam. Drink 32 oz. of water the evening prior and 32 oz. of water the morning of your exam. Oral contrast will not be required if your diagnosis is Hematuria (blood in urine), Kidney stones, Hydronephrosis, ureteral or bladder calculi.

Barium Oral Contrast: Drink the 1<sup>st</sup> provided bottle the evening before your exam. The 2<sup>nd</sup> bottle must be FINISHED 1 hour prior to scheduled exam time **OR** arrive 2 hours early to drink oral contrast.

Gastrografin Oral Contrast: Arrival time to be provided at time of scheduling.

### Mammography

Do not wear lotion, deodorant, perfume or powder under your arms or on your breasts. Please inform your scheduler of any family or personal history of breast cancer, surgeries, biopsies, implants or hormone use.

**We require you to bring prior images AND reports from Centrelake and outside facilities for mammograms, breast biopsy, breast MRI, breast ultrasound, etc.**

Mammograms cannot be performed if you are pregnant. Women who may be pregnant or breastfeeding should always inform their scheduler & technologist.

### Ultrasound

**TABLE WEIGHT LIMIT: 500lbs**

<b>Abdomen Liver Gallbladder Right Upper Quad</b>	Nothing by mouth 8 hrs prior to your exam. Diabetics may have limited crackers and take their medications with limited water.
<b>All Pelvic Exams All Bladder Exams Prostate Obstetrical Kidney/Renal Renal Doppler</b>	You are required to drink <b>32 oz. of water 1 hour prior</b> to your exam. <b>DO NOT</b> urinate prior to the completion of exam.
<b>Breast Ultrasound 30 years or older</b>	You are recommended to have a mammogram with or before your ultrasound procedure. You are <u>required</u> to bring your previous breast radiology images and reports.
<b>Breast Ultrasound 29 years or younger</b>	No preparation required. Prescription or referring provider's notes must indicate the specific exam location and purpose of the study. You are <u>required</u> to bring your previous breast radiology images and reports.
<b>The following examinations do not require any preparations:</b> Carotids, Arterial, Venous, ABI, Testicular, Reflux, Infant hips, Soft tissue & Thyroid exams.	

### X-RAY

**TABLE WEIGHT LIMIT: 300lbs (450lbs - Chino & Ontario; 600lbs - El Monte)**

You may follow your usual diet and medicine routines. Please bring prior images and reports for comparative analysis. Refrain from wearing jewelry or hair accessories.

X-Rays cannot be performed if you are currently pregnant. Women who may be pregnant should always inform their technologist. X-Rays cannot be performed if you have ingested any oral contrast within 24 hours prior to your exam.

### Bone Densitometry

**TABLE WEIGHT LIMIT: 300lbs**

**Please refrain from taking calcium or vitamin D supplements for at least 24 hours beforehand.** Please do not wear clothing with metallic buttons or zippers located below the waist (front or back). Patients will be required to change into a gown that will be provided to you if your clothing will affect the image. Sweat pants or clothing without zippers are highly recommended.

### ANAHEIM

1900 E La Palma Ave, #D  
 Anaheim, CA 92805  
 3T MRI/MRA, CT/CTA, X-ray  
 Ultrasound, Mammo, DEXA

### DOWNEY

10226 Lakewood Blvd  
 Downey, CA 90241  
 MRI/MRA, CT/CTA, PET/CT  
 Ultrasound, Echocardiography  
 Nuc Med, X-Ray, Mammo, DEXA

### CHINO

5562 Philadelphia St, #100  
 Chino, CA 91710  
 X-Ray, Ultrasound  
 Mammo, DEXA

### ONTARIO

3115 E Guasti Rd  
 Ontario, CA 91761  
 MRI/MRA, CT/CTA, PET/CT  
 Nuclear Medicine, X-Ray  
 Ultrasound, Mammo, DEXA

### COVINA

1433 N Hollenbeck Ave, #105  
 Covina, CA 91722  
 X-Ray, Ultrasound, Mammo  
 Echocardiography

### POMONA

1555 N Orange Grove Ave  
 Pomona, CA 91767  
 MRI/MRA, CT/CTA, X-Ray  
 Ultrasound, Echocardiography  
 Mammo, DEXA

### EL MONTE

11436 Garvey Ave, #D  
 El Monte, CA 91732  
 OPEN MRI, Ultrasound, X-Ray  
 Mammo, DEXA

### WEST COVINA

1700 W West Covina Pkwy  
 West Covina, CA 91790  
 MRI/MRA CT/CTA  
 X-Ray, Ultrasound  
 Mammo, DEXA

### UPLAND

1183 E Foothill Blvd, #235  
 Upland, CA 91786  
 Ultrasound  
 X-Ray

### HEMET

430 W Stetson Ave  
 Hemet, CA 92543  
 3T MRI/MRA, PET/CT  
 X-Ray, Ultrasound  
 Mammo, DEXA

Name:	DOB:	Mobile Phone:
Insurance Carrier:	Insurance ID:	Today's Date:
IPA:	Referring Provider (print first and last name):	
Auth #:	Phone #:	Fax #:

**STAT** After-hours Provider Phone # for Critical Findings: \_\_\_\_\_

Copy Report to Physician, Name/Fax: \_\_\_\_\_  Patient to return with CD

## EXAM REQUESTED

\* For CT IV contrast exams, labs within 30 days required for patients 60 yrs. or older. Please fax lab results to (909) 784-3760.

MRI	CT	ULTRASOUND	PET/CT
<input type="checkbox"/> With & without contrast <input type="checkbox"/> Without contrast <input type="checkbox"/> Open MRI (El Monte only) <b>Head &amp; Neck</b> <input type="checkbox"/> Brain <input type="checkbox"/> Angio Brain <input type="checkbox"/> IAC <input type="checkbox"/> Orbits <input type="checkbox"/> Angio Neck <input type="checkbox"/> TMJ <input type="checkbox"/> Pituitary <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Brain Venography <b>Body/Trunk</b> <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Prostate <input type="checkbox"/> Pelvis <input type="checkbox"/> Angio Abd. <input type="checkbox"/> MRCP <b>Breast</b> <input type="checkbox"/> Breast Cancer Screening w/contrast <input type="checkbox"/> Implants without contrast <b>Spine</b> <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Sacrum <b>Extremity</b> <input type="checkbox"/> Shoulder L / R <input type="checkbox"/> Hip L / R <input type="checkbox"/> Elbow L / R <input type="checkbox"/> Knee L / R <input type="checkbox"/> Wrist L / R <input type="checkbox"/> Ankle L / R <input type="checkbox"/> Hand L / R <input type="checkbox"/> Foot L / R <input type="checkbox"/> Arthrogram (West Covina & Downey only): <div style="text-align: right;">L / R</div> <input type="checkbox"/> Extremity: Upper / Lower; L / R / B <input type="checkbox"/> Angio Lower Extremity Run-off <input type="checkbox"/> Other MRI, Specify: _____ <b>ECHOCARDIOGRAPHY</b> <input type="checkbox"/> Echocardiogram	<input type="checkbox"/> Without contrast <input type="checkbox"/> With contrast* <input type="checkbox"/> With & without contrast* <b>Head &amp; Neck</b> <input type="checkbox"/> Brain <input type="checkbox"/> Temporal Bones <input type="checkbox"/> Sinus <input type="checkbox"/> Orbits <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> IAC <input type="checkbox"/> Face/Mandible/Maxillofacial <input type="checkbox"/> Angio: Brain / Neck / Carotid <b>Body/Trunk</b> <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Urogram <input type="checkbox"/> Abdomen & Pelvis <input type="checkbox"/> Angio Pelvis <input type="checkbox"/> Angio Chest <input type="checkbox"/> Angio Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Angio Abdomen & Pelvis <input type="checkbox"/> Angio Pulmonary <input type="checkbox"/> Low Dose Lung Cancer Screening <input type="checkbox"/> Low Dose Abd/Pelvis Hernia Eval. <b>Spine</b> <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Sacrum <b>Extremity</b> <input type="checkbox"/> Shoulder L / R <input type="checkbox"/> Hip L / R <input type="checkbox"/> Elbow L / R <input type="checkbox"/> Knee L / R <input type="checkbox"/> Wrist L / R <input type="checkbox"/> Ankle L / R <input type="checkbox"/> Hand L / R <input type="checkbox"/> Foot L / R <input type="checkbox"/> Arthrogram (West Covina & Downey only): <div style="text-align: right;">L / R</div> <input type="checkbox"/> Extremity: Upper / Lower <input type="checkbox"/> Angio Lower Extremity <input type="checkbox"/> Angio Aorta/Bilateral Run-Off <input type="checkbox"/> Other CT, Specify: _____	<b>Abdomen &amp; Pelvis</b> <input type="checkbox"/> Abdomen Complete <input type="checkbox"/> Appendix <input type="checkbox"/> Hernia <input type="checkbox"/> Pelvis Transabdominal/Transvaginal <input type="checkbox"/> Pelvis Transabdominal only <input type="checkbox"/> Pelvis Limited, Bladder only <input type="checkbox"/> Renal Arterial Complete <input type="checkbox"/> Kidney Bilateral <input type="checkbox"/> Abdominal Aorta <b>Extremity Doppler</b> <input type="checkbox"/> Venous <input type="checkbox"/> Arterial <input type="checkbox"/> Lower L / R / B <input type="checkbox"/> Upper L / R / B <input type="checkbox"/> Vein Mapping Bilateral <input type="checkbox"/> Venous Lower Bilateral w/ Reflux (for Venous Insufficiency Only) <b>Breast</b> <input type="checkbox"/> Bilateral <input type="checkbox"/> Unilateral L / R <b>Obstetrics</b> <input type="checkbox"/> OB Complete <input type="checkbox"/> OB Under 14 Wks <b>Other</b> <input type="checkbox"/> Thyroid <input type="checkbox"/> Scrotum <input type="checkbox"/> Carotid <input type="checkbox"/> Prostate <input type="checkbox"/> Head/Neck Soft Tissue <input type="checkbox"/> Soft Tissue, Specify: _____ <input type="checkbox"/> Specify: _____ <b>MAMMOGRAPHY</b> <input type="checkbox"/> Screening <input type="checkbox"/> Diagnostic <input type="checkbox"/> Implants <input type="checkbox"/> Unilateral: L / R <input type="checkbox"/> Spot Compression Prior breast images and reports required for exams performed at Centrelake and outside facilities Date of last Mammo: _____	<input type="checkbox"/> Whole Body <input type="checkbox"/> Head to Thigh <div style="border: 1px solid red; padding: 5px; margin: 5px 0;"> <b>ATTN PET Patients:</b> Minimum 24 business hours notice for cancellation with a live Centrelake agent (no voicemails/emails/web messages) to avoid \$500 wasted material fee.                 </div> <b>NUCLEAR MEDICINE</b> <input type="checkbox"/> Cardiolyte Stress <input type="checkbox"/> Liver/Spleen <input type="checkbox"/> Parathyroid <input type="checkbox"/> Gallbladder <input type="checkbox"/> Thyroid Scan Only <input type="checkbox"/> Thyroid I-123 <input type="checkbox"/> Bone Whole Body <input type="checkbox"/> Bone 3 Phase <input type="checkbox"/> Bone Limited, Specify: _____ <input type="checkbox"/> Renal, Diuretic: Y / N <input type="checkbox"/> Hepatobiliary, CCK: Y / N <input type="checkbox"/> Other: _____ <div style="border: 1px solid red; padding: 5px; margin: 5px 0;"> <b>ATTN Nuclear Patients:</b> Minimum 24 business hours notice for cancellation with a live Centrelake agent (no voicemails/emails/web messages) to avoid up to \$3,500 wasted material fee.                 </div> <b>DIGITAL X-RAY</b> Walk-in Only M-F 8:30am-4:30pm*. No appts. <input type="checkbox"/> Specify Area(s) & Views: _____ _____ _____ _____ * Closed for lunch, 12pm-1pm. Weight bearing foot & ankle only in Ontario, Pomona, Anaheim and Hemet. <b>BONE DENSITOMETRY</b> <input type="checkbox"/> Dexa Bone Screening (hip & spine) Date of last Dexa: _____

Please list any signs/symptoms and fax all clinical information and prior images/reports from Centrelake and outside facilities which are pertinent to this exam to (909) 784-3760.

Please Include ICD Code(s): \_\_\_\_\_

Referring Provider Signature (Required for Exam) \_\_\_\_\_