

*This form must be received by Jefferson Radiology prior to appointment*

<b>LOCATION</b> <input type="checkbox"/> Avon <input type="checkbox"/> Bloomfield <input type="checkbox"/> Enfield <input type="checkbox"/> Farmington <input type="checkbox"/> Glastonbury <input type="checkbox"/> Granby <input type="checkbox"/> Hartford <input type="checkbox"/> West Hartford <input type="checkbox"/> Wethersfield	Patient Name: _____ DOB: _____ Wt: _____ lbs.
	Phone(H): _____ Other Phone: _____ Claustrophobia: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Insurance: _____ Secondary Ins.: _____
	Insurance ID#: _____ Sec. Insurance ID#: _____
	Authorization #: _____ Sec. Authorization #: _____ <i>Insurance authorization # (when required) <b>must</b> be received by Jefferson Radiology prior to appointment.</i>
	Creatinine: _____ Date drawn: _____ / _____ / _____ <i>(Required for CT contrast, within 90 days of appointment for patients over 65 years of age, with kidney disease or diabetes.)</i>

**Specific Exam Requested:** \_\_\_\_\_

**Signs & Symptoms** ICD-10 requires listing of **primary** and **secondary** diagnosis (MUST LIST SPECIFICS, "rule out," "history of" or "question of" is **not** sufficient for insurance):

Acute Chronic Injury related? Yes No Date of injury: \_\_\_\_\_

<b>EXAM:</b> <input type="checkbox"/> CT <input type="checkbox"/> Interventional <input type="checkbox"/> MRI <i>Screening orbits if clinically indicated</i> <input type="checkbox"/> Nuclear Med <input type="checkbox"/> Ultrasound <input type="checkbox"/> X-ray <hr/> <input type="checkbox"/> No contrast <input type="checkbox"/> W/O & with IV Contrast <input type="checkbox"/> With Intraarticular Contrast <hr/> <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> BILATERAL <hr/> <input type="checkbox"/> 3D RECONSTRUCTIONS	<b>ANATOMICAL AREA:</b> <input type="checkbox"/> Head _____ <b>UPPER EXTREMITY</b> <input type="checkbox"/> Shoulder <input type="checkbox"/> Humerus <input type="checkbox"/> Elbow <input type="checkbox"/> Ulna/Radius <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Finger <hr/> <b>LOWER EXTREMITY</b> <input type="checkbox"/> Hip <input type="checkbox"/> Pelvis <input type="checkbox"/> Femur <input type="checkbox"/> Knee <input type="checkbox"/> Tib/Fib <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> Other: _____	<b>SPINE</b> <input type="checkbox"/> C-Spine <input type="checkbox"/> T-Spine <input type="checkbox"/> L-Spine <input type="checkbox"/> Sacrum/Coccyx <b>PROCEDURE</b> <input type="checkbox"/> Discogram with CT <input type="checkbox"/> Vertebral Augmentation (Kypho) <input type="checkbox"/> Other: _____ <hr/> <b>U/S</b> <input type="checkbox"/> Venous Doppler <input type="checkbox"/> Other: _____ <hr/> <b>NUCLEAR MEDICINE</b> <input type="checkbox"/> Bone Scan <input type="checkbox"/> SPECT <input type="checkbox"/> 3 Phase Bone Studies <input type="checkbox"/> Bone/Gallium Subtraction <input type="checkbox"/> White Blood Cell Scan <input type="checkbox"/> Other: _____	<b>THERAPEUTIC INJECTIONS</b> <input type="checkbox"/> ESI Cervical <input type="checkbox"/> ESI Lumbar <input type="checkbox"/> Transforaminal Injection <input type="checkbox"/> Thoracic (CT Guided) <hr/> <input type="checkbox"/> Lumbar _____ <input type="checkbox"/> Facet Injection <input type="checkbox"/> Cervical _____ <input type="checkbox"/> Thoracic _____ <input type="checkbox"/> Lumbar _____ <input type="checkbox"/> Sacroiliac Joint Injection <input type="checkbox"/> Joint Aspiration <input type="checkbox"/> U/S MSK Procedure <input type="checkbox"/> Baker's Cyst Aspiration/Injection <input type="checkbox"/> Biceps Tendon Sheath Injection <input type="checkbox"/> Other: _____
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Referring MD (print name): \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Referring MD (required): \_\_\_\_\_

CC Provider Name(s): \_\_\_\_\_ CC Patient

**APPT. DATE:** \_\_\_\_\_ **APPT. TIME:** \_\_\_\_\_ **AM / PM** **LOCATION:** \_\_\_\_\_

# Scheduling Your Imaging Exam

To best serve you, our team will be in touch to schedule your exam. Please do not hesitate to contact us for immediate scheduling.

Appointment date: \_\_\_\_\_ Appointment time: \_\_\_\_\_ Location: \_\_\_\_\_

Scheduling: 860-289-3375 | [www.jeffersonradiology.com](http://www.jeffersonradiology.com)

OFFICE	DIRECTIONS	Vascular Ultrasound	General Radiology (X-Ray)	3D Tomosynthesis	Bone Densitometry	Digital Mammography	Nuclear Medicine	Ultrasound	CT Scan	Open MRI (High Field)	3T MRI (High Field)	MRI (High Field)
<input type="checkbox"/> 100 Simsbury Road, Suite 101 Avon, CT 06001	From Simsbury, follow <b>Route 10 South</b> to light. Turn L into Avon Wellness Center. From <b>I-84 East or West</b> , take Exit 39. Go straight onto Route 4 W to intersection of Routes 10/202. Turn R on Route 10 N to Route 44. Turn L on Route 44 W. Turn R on Route 10/202 N. Go 1/4 mile and turn R into parking lot at light (Avon Wellness Center).	■	■	■	■	■	■	■	■			■
<input type="checkbox"/> 6 Northwestern Drive, Suite 102 Bloomfield, CT 06002	From <b>I-91 South</b> , take exit 35B. At the end of the ramp, turn R onto Route 218 and go approximately 4.4 miles. After railroad tracks turn L at light onto Northwestern Drive. From <b>I-91 North</b> , take exit 35B. At the end of the ramp, turn L onto Route 218 and go approximately 4.4 miles. After railroad tracks turn L at light onto Northwestern Drive. From <b>I-291W</b> take Exit 1 for CT-218. Merge onto Putnam Hwy. Turn L onto Route 218 and go approximately 2.6 miles. After railroad tracks turn L at light onto Northwestern Drive.	■	■	■	■	■	■	■	■	■		
<input type="checkbox"/> 100 Hazard Avenue, Suite 100 Enfield, CT 06082	From <b>I-91 North or South</b> , take Exit 47 E, go through 6 traffic lights. The driveway is on the right.	■	■	■	■	■	■	■	■			■
<input type="checkbox"/> 399 Farmington Avenue, First Floor Farmington, CT 06032	From <b>I-91 North or South</b> , take Exit 32A(84 West). Take 84 W to Exit 39. At end of ramp, take R at 1st light onto Farmington Avenue. Take R at 1st light onto South Road. Take L at 1st light into Farmington Medical Arts Center. From <b>84 East or West</b> , take Exit 39. At end of ramp, take R at 1st light onto Farmington Avenue. Take R at 1st light onto South Road. Take L at 1st light into Farmington Medical Arts Center.	■	■	■	■	■	■	■	■			■
<input type="checkbox"/> 704 Hebron Avenue, Suite 100 Glastonbury, CT 06033	From <b>Route 2 West</b> , take Exit 8. Turn R on Oak Street, R on Hebron Avenue, R on Oakwood Drive (entrance on L). From Route 3 E and I-84 E or W to <b>Route 2 East</b> , take Exit 8 off of Route 2. Turn L on Hebron Avenue, then R on Oakwood Drive (entrance on L).	■	■	■	■	■	■	■	■			■
<input type="checkbox"/> 18 East Granby Road, Suite 202 Granby, CT 06035	From <b>I-91 North or South</b> , take exit 40 (Bradley International Airport). Merge onto Route 20. Take fourth exit for Route 20 East Granby, Granby. Travel approximately 5 miles. Turn R into parking lot (across from Geissler's Supermarket). From <b>CT-219N/Gavitt Rd</b> - Turn R onto CT-20E/ Hartland Road and go approximately 3.6 miles. Turn R onto Salmon Brook Street. Take first L onto East Granby Road. Office will be on left.		■	■	■	■						
<input type="checkbox"/> 85 Seymour Street, Suite 200 Hartford, CT 06106	From <b>I-91 North or South</b> , take Exit 29A. Go around rotary and take Hudson Street to the end. Turn R on Jefferson Street, then L on Seymour Street. From <b>I-84 West</b> , take Exit 54. Go over Founders Bridge. At light turn L onto Columbus Blvd. Follow blue H (hospital) signs. Turn L onto Seymour Street. From <b>I-84 East</b> , take Exit 48A/48B (Asylum Street/Capitol Avenue). Turn L onto Capitol Avenue. Turn R onto Washington Street. Go through light at intersection of Washington Street and Jefferson Street, at next light L onto Seymour Street.	■	■	■	■	■	■	■	■			
<input type="checkbox"/> 941 Farmington Avenue West Hartford, CT 06107	From <b>I-84 East or West</b> , take Exit 43. Turn R on Park Road, then immediate L onto Trout Brook Drive. Turn L on Farmington Avenue (office on L). From <b>Route 44 East</b> , turn R on North Main Street, then L onto Farmington Avenue (office on R).	■	■	■	■	■	■	■	■			■
<input type="checkbox"/> 1260 Silas Deane Highway, Suites 100 & 104 Wethersfield, CT 06109	From south of Wethersfield take <b>I-91 North</b> and take Exit 24. Turn R on Silas Deane Highway (office on R). From north of Wethersfield take <b>I-91 South</b> and take Exit 24. Turn L onto Silas Deane Highway (office on R). From <b>Route 3 West</b> , turn L on Silas Deane Highway (Route 99). Office is about 1 mile on L. From <b>Route 175 E</b> (Cedar Street in Wethersfield), turn R on Silas Deane Highway (office about 3 1/2 miles on L).	■	■	■	■	■	■	■	■			■

**PATIENT INSTRUCTIONS** — If prior images are not at Jefferson Radiology, please bring films or images on a CD at time of appointment. For breast imaging patients, please bring your last five (5) years of imaging history. If you have an appointment for any of the examinations listed below, please follow the instructions for preparation unless they are modified by your own doctor or by us.

**ALL PATIENTS MAY BE REQUIRED TO CHANGE.**

## PATIENT INSTRUCTIONS FOR GENERAL X-RAY

- MAMMOGRAPHY:** Do not use any deodorant, cream or powder in the underarm or breast area prior to the examination.
- BONE DENSITOMETRY:** This examination should not be done within 2 weeks of a nuclear medicine procedure, within 1 week of any contrast study or 48 hours post barium study. Do not take calcium supplements for 24 hours prior to examination.

## PATIENT INSTRUCTIONS FOR ULTRASOUND EXAMINATIONS

- PREGNANCY OR PELVIC ULTRASOUND:** Drink 32 oz. of water and FINISH drinking 60 minutes before scheduled exam. Do not urinate until the exam is complete. Males: no prep required.
- ENDOVAGINAL ULTRASOUND:** No prep.
- ABDOMINAL ULTRASOUND (Gallbladder, Aorta, Liver):** Nothing to eat or drink (including water) 6 hours prior to your exam.
- RENAL ULTRASOUND:** Drink 24 oz. of water and FINISH drinking 60 minutes before scheduled exam. Do not urinate until the exam is complete.

## PATIENT INSTRUCTIONS FOR MRI / MRA OF THE ABDOMEN AND THE PELVIS

- Nothing to eat or drink (including water) 4 hours prior to your exam.

## PATIENT INSTRUCTIONS FOR CT SCAN

- GENERAL INSTRUCTIONS FOR CT SCAN:** Nothing to eat or drink (including water) during the two hour period before your appointment. Medications may be taken normally and a list should be brought to your appointment.
- CT SCAN OF HEAD, NECK, CHEST:** Follow general instructions above.
- CT SCAN OF ABDOMEN/PELVIS:** Patients will need to drink a Readi-Cat solution 1-1/2 hour prior to their exam. Patients can either pick up the solution prior to their appointment or arrive 1-1/2 hour before their exam and drink it on site. Readi-Cat can be picked up at any of our Jefferson Radiology locations. Patients should not eat 2 hours prior to exam if they are having IV contrast.

## PATIENT INSTRUCTIONS FOR NUCLEAR MEDICINE

- BONE SCAN:** No restrictions. Allow 15 minutes for injection. You will return 2-1/2 to 3-1/2 hours later for imaging. Allow 1 hour for the examination. Wear comfortable clothing.
- BILIARY SCAN:** Nothing to eat or drink for 4 hours before the scan. No pain medication 4 hours prior to the exam. Allow 2 hours for the examination.
- GASTRIC EMPTYING SCAN:** Nothing to eat or drink for 4 hours before the scan. Allow 2-4 hours for the examination.
- CAPTROPRIl RENAL SCAN (2-day Exam):** Certain blood pressure medications may need to be stopped for this procedure. This should be discussed with your doctor.
- THYROID UPTAKE AND SCAN (2-day Exam) / PARATHYROID SCAN (1-day Exam) / THYROID SCAN (1-day Exam):** Certain medications need to be stopped before this procedure. This can be discussed with your doctor.