North Houston X-Ray
& Imaging Center

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Patient Name ______________________ D/O/B ______________________

Diagnosis ______________________ Patient Phone # ______________________

	☐ Without Contrast ☐ W & W/O Contrast ☐ With Contrast **MRI**	x	☐ Without Contrast ☐ W & W/O Contrast ☐ With Contrast **CT**		**X-RAY** (All X-Rays are Routine Views, Unless Noted)		
	SPINE/NEURO		Abdomen		**EXTREMITIES**		**ABDOMEN & PELVIS**
	Brain		Abdomen & Pelvis		Ankle L R		Abdomen KUB
	Brain w/IAC		Pelvis		Elbow L R		Abdomen Supine & Erect
	Brain w/Pituitary		Head/Brain		Femur L R		Pelvis
	Brain w/Sinuses		Orbit/Ear/Fossa		Finger L R		CHEST
	Orbits		Sinus/Maxillofacial		Foot L R		Chest (PA)
	TMJ		Chest		Forearm L R		Chest (PA & LAT)
	Chest/Thorax		Soft Tissue Neck		Hand L R		Lordotic View
	Soft Tissue Neck		Cervical Spine		Hip L R		Ribs L R
	Cervical Spine		Thoracic Spine		Humerus L R		Sternum
	Thoracic Spine		Lumbar Spine		Knee L R		Sternoclavicular Joints
	Lumbar Spine		UPPER EXTREMITY		Heel (Os Calcis) L R		**SHOULDER REGION**
	UPPER EXTREMITY		Shoulder L R		Leg (Tib/Fib) L R		Clavicle L R
	Shoulder L R		Humerus L R		Toe(s) L R		Scapula L R
	Scapula L R		Elbow L R		Wrist L R		Shoulder L R
	Humerus L R		Forearm L R		**HEAD**		Shoulder AC Joints L R
	Elbow L R		Wrist L R		Facial Bones		**SPINE & PELVIS**
	Forearm L R		Hand L R		Mandible		Cervical Spine
	Wrist L R		LOWER EXTREMITY		Mastoids		Thoracic Spine
	Hand L R		Hip L R		Nasal Bones		Lumbar Spine
	LOWER EXTREMITY		Femur L R		Orbits		Sacrum & Coccyx
	Ankle L R		Knee L R		Sellaturcica		SI Joints
	Femur L R		Tib/Fib (Leg) L R		Sinus Paranasal		Scoliosis Thoracolumbar
	Foot L R		Ankle L R		Skull		Soft Tissue for Neck
	Hip L R		Foot L R		TM Joints		Other
	Knee L R		Other		Zygomatic Arches		
	Tib/Fib L R				**ULTRASOUND**		**CARDIAC/VASCULAR**
	Pelvis		**CT ANGIOGRAPHY**		Abdomen		Echocardiogram (M.Mode,2DColorDoppler)
	Abdomen		Angio Abdomen		Gallbladder		
	MRCP		Angio Abdomen Aorta		Kidney/Renal		Carotid Doppler
Other			Angio Abdomen & Pelvis		Liver		Venous Doppler Upper Ext.
			Angiography Head		OB -Complete		Venous Doppler Lower Ext.
			Angiograph Chest		Pelvic Transabdominal		Arterial Doppler Upper Ext.
	MRA		Angiograph Neck		Pelvic Transvaginal		Arterial Doppler Lower Ext.
	Abdomen/Renal		Angio Pelvis		Thyroid		Other
	Head/Circle Of Willis w/o		Angio Lower Extremity		Prostate Transabdominal		
	Carotid/Neck w/o		Angio Upper Extremity		Testicular/Scrotum		
			Other		Soft Tissue (Mass)		
					Soft Tissue (Extremity)		
Other					Other		

*FOR CONTRAST PATIENTS	BUN:	CREATINE:	Date of Blood work
Physician Name	**Physician Signature**	**Phone:** **Fax:**	**Date**