



**Park Place MRI & Diagnostics**  
 6800 North Dale Mabry Hwy  
 Suite #144  
 Tampa, FL 33614  
 Phone: 813-886-9999  
 Fax: 813-885-2800

Patient's Name: \_\_\_\_\_  
 First Last  
 Date of Birth: \_\_\_\_\_ Home # \_\_\_\_\_ Alt. # \_\_\_\_\_

TO AVOID BEING RESCHEDULED, PLEASE FAX THIS PRESCRIPTION ALONG WITH  
 AUTHORIZATION/REFERRAL (IF REQUIRED) BY 5:00P.M. THE DAY PRIOR TO THE EXAM

**PHYSICIAN'S PRESCRIPTION**

**MRI**

**16 SLICE CT SCAN**

**XRAY**

**ULTRASOUND**

- W/ contrast**       **W/O contrast**  
 Abdomen attn to: \_\_\_\_\_  
 Brain  
 Brain (trauma w/ SWI)  Cervical  
 Breast       Cervical + Alar  
 Chest       Cervical + Flex & Ext  
 IACs       Thoracic  
 MRCP       Lumbar  
 Neck - Soft Tissue       Weight Bearing  
 Orbits  
 Pelvis  
 Pituitary Gland  
 TMJ

- W/ contrast**       **W/O contrast**  
 Abdomen attn to: \_\_\_\_\_  
 Pelvis  
 Urogram       Cervical  
 Chest       Thoracic  
 Brain       Lumbar  
 IAC/ Mastoid/ Orbits  
 Neck- Soft Tissue  
 Sinus/ Facial Bones  
 Virtual Colonoscopy  
 Cardiac (Calcium) Score

- (Vw = # of Views)  
 Abdomen (KUB)  
 Chest Vw \_\_\_\_\_  
 Heel R L Vw \_\_\_\_\_  
 Orbits R L Vw \_\_\_\_\_  
 Ribs R L Vw \_\_\_\_\_  
 Sacroiliac Joint  
 Cervical Vw \_\_\_\_\_  
 Lumbar Vw \_\_\_\_\_  
 Thoracic Vw \_\_\_\_\_  
 Elbow R L Vw \_\_\_\_\_  
 Forearm R L Vw \_\_\_\_\_  
 Hand R L Vw \_\_\_\_\_  
 Humerus R L Vw \_\_\_\_\_  
 Shoulder R L Vw \_\_\_\_\_  
 Wrist R L Vw \_\_\_\_\_  
 Ankle R L Vw \_\_\_\_\_  
 Femur R L Vw \_\_\_\_\_  
 Foot R L Vw \_\_\_\_\_  
 Hip R L Vw \_\_\_\_\_  
 Knee R L Vw \_\_\_\_\_  
 Tibia/Fibula R L Vw \_\_\_\_\_

- Abdomen Complete  
 Abdomen Limited Attn to: \_\_\_\_\_  
 Aorta  
 Arterial Lwr Ext R L  
 Arterial Upr Ext R L  
 Breast R L  
 Carotid  
 Non-Vascular Lwr Ext R L  
 Non-Vascular Upr Ext R L  
 OB \_\_1st Tri \_\_2-3 Tri  
 Pelvic (Transabdominal)  
 Prostate (Transrectal)  
 Renal Artery Doppler  
 Retroperitoneal (Kidneys & Bladder)  
 Soft Tissue  
 Testicular  
 Thyroid  
 Transvaginal (Including Pelvis)  
 Transvaginal (Alone)  
 Venous Upr Ext R L  
 Venous Lwr Ext R L

**EXTREMITIES**

- Elbow R L  Ankle R L  
 Hand R L  Foot R L  
 Shoulder R L  Hip R L  
 Wrist R L  Knee R L

- EXTREMITIES**  
 Elbow R L  Ankle R L  
 Hand R L  Foot R L  
 Shoulder R L  Hip R L  
 Wrist R L  Knee R L

Arthrogram Y N Arthrogram Y N

**MRA / MRV**

- MRA Aorta Run Off  
 MRA Abdomen  
 MRA Brain       MRV Brain  
 MRA Lwr Ext R L  
 MRA Neck       MRV Neck  
 MRA Pelvis       MRA Renals

**CTA**

- CTA Abdomen       CTA Brain  
 CTA Carotid       CTA Chest  
 CTA Pelvis       CTA Runoff  
 CTA Lwr Ext R L  
 CTA Upr Ext R L

Other: \_\_\_\_\_

Other: \_\_\_\_\_

**COMPARISON REQUIRED**  
 Scan done on \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Patient has films / report  
 Contact \_\_\_\_\_  
 for films / report.

DIAGNOSIS CODE(S): \_\_\_\_\_  Acute       Chronic

Physician's Printed Name \_\_\_\_\_

Physician's Signature \_\_\_\_\_

Date \_\_\_\_\_