

Date: ____/____/____

MD Phone: _____

Patient Last Name: _____

Referring Physician Signature: _____

Patient First Name: _____

Referring Physician Name: _____

DOB: ____/____/____ ICD 10: _____

Clinical History: _____

Patient Phone Number: _____

Payment Tier: Tier 1 Tier 2 FULL

- | | |
|--|--|
| <input type="checkbox"/> without contrast | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> with contrast | <input type="checkbox"/> LEFT |
| <input type="checkbox"/> with & without contrast | <input type="checkbox"/> BILATERAL |
| <input type="checkbox"/> per radiologist | <input type="checkbox"/> OPEN (Oakland & Concord only) |

MRI - All Locations

- | | |
|--|--|
| <input type="checkbox"/> C-spine | <input type="checkbox"/> MRA Brain |
| <input type="checkbox"/> T-spine | <input type="checkbox"/> MRA Carotids/Neck |
| <input type="checkbox"/> L-spine | <input type="checkbox"/> Brachial Plexus |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Chest |
| <input type="checkbox"/> Elbow | <input type="checkbox"/> Abdomen |
| <input type="checkbox"/> Wrist | <input type="checkbox"/> MRCP w/ 3-D Recons |
| <input type="checkbox"/> Hand | <input type="checkbox"/> Pelvis Soft Tissue
(GYN pelvic mass) |
| <input type="checkbox"/> Hip | <input type="checkbox"/> Pelvis Bony
(stress fracture/hamstring strain, etc.) |
| <input type="checkbox"/> Knee | <input type="checkbox"/> Upper Extremity non-joint |
| <input type="checkbox"/> Ankle | <input type="checkbox"/> Lower Extremity non-joint |
| <input type="checkbox"/> Foot/Forefoot | <input type="checkbox"/> MRA Chest |
| <input type="checkbox"/> Pituitary | <input type="checkbox"/> MRA Renal |
| <input type="checkbox"/> Soft Tissue Face/Neck | <input type="checkbox"/> MRA Abdomen (aorta) |
| <input type="checkbox"/> TMJ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Brain | |

CT - Fremont & San Jose

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> C-spine |
| <input type="checkbox"/> Neck | <input type="checkbox"/> T-spine |
| <input type="checkbox"/> Temporal Bones | <input type="checkbox"/> L-spine |
| <input type="checkbox"/> Sinuses | <input type="checkbox"/> Chest |
| <input type="checkbox"/> Facial Bones | <input type="checkbox"/> Extremity |
| <input type="checkbox"/> Abdomen/Pelvis | <input type="checkbox"/> Mandible |
| <input type="checkbox"/> Liver (Dynamic) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Renal Calculi | |

Ultrasound - All Locations

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Neck ST | <input type="checkbox"/> Carotid |
| <input type="checkbox"/> Pelvis | <input type="checkbox"/> Scrotum | <input type="checkbox"/> DVT |
| <input type="checkbox"/> Pelvis + EV | <input type="checkbox"/> Breast | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Renal/Bladder | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> Bladder post-void | <input type="checkbox"/> OB | <input type="checkbox"/> LEFT |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> NT screen | <input type="checkbox"/> BILATERAL |

MR Arthrography - San Ramon & Fremont

Fluoroscopic Guided Pain Injection - San Ramon & Fremont

X-Ray - All Locations

- | | | |
|------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Chest | <input type="checkbox"/> Wrist | <input type="checkbox"/> Neck |
| <input type="checkbox"/> Ribs | <input type="checkbox"/> Hand/Fingers | <input type="checkbox"/> Sinuses |
| <input type="checkbox"/> C-spine | <input type="checkbox"/> Pelvis | <input type="checkbox"/> Mandible/TMJ |
| <input type="checkbox"/> T-spine | <input type="checkbox"/> Hip | <input type="checkbox"/> Skull |
| <input type="checkbox"/> L-spine | <input type="checkbox"/> Knee | <input type="checkbox"/> Sacrum/Coccyx |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Ankle | <input type="checkbox"/> S.I. Joints |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Tib/fib | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Humerus | <input type="checkbox"/> Foot/toes | <input type="checkbox"/> RIGHT |
| <input type="checkbox"/> Elbow | <input type="checkbox"/> Abdomen (3V) | <input type="checkbox"/> LEFT |
| <input type="checkbox"/> Forearm | <input type="checkbox"/> Abdomen (1V) | <input type="checkbox"/> BILATERAL |

Mammography - Lafayette, Fremont, Oakland, San Jose, Concord

- | | | |
|-------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Screening | <input type="checkbox"/> Diagnostic | <input type="checkbox"/> Breast Ultrasound |
| <input type="checkbox"/> Unilateral | <input type="checkbox"/> Bilateral | <input type="checkbox"/> Implants |

LAFAYETTE
970 Dewing Ave. #100
Lafayette, CA 94549
P: (925) 297-6460
F: (925) 297-6459
NPI: 1598859100
MRI, X-ray, Ultrasound
Digital Mammography
3D Tomographic
Mammography
Bone Densitometry

FREMONT
39465 Paseo Padre Pkwy.
#1000
Fremont, CA 94538
P: (510) 490-0961
F: (510) 490-0971
NPI: 1447241302
MRI, CT, X-ray, Ultrasound
Digital Mammography

OAKLAND
1940 Webster St. #100
Oakland, CA 94612
P: (510) 451-0780
F: (888) 480-6615
NPI: 1598859100
Open MRI
1.2 High Field Open

OAKLAND
3300 Webster St. #109
Oakland, CA 94609
P: (510) 451-0780
F: (510) 451-2352
NPI: 1598859100
X-ray, Ultrasound
Digital Mammography
Bone Densitometry

WEST SAN JOSE
798 S. Winchester Blvd.
San Jose, CA 95128
P: (408) 984-7226
F: (408)-984-7225
NPI: 1083720304
MRI, CT, X-ray, DEXA,
Ultrasound

EAST SAN JOSE
2324 Montpelier Dr. #7
San Jose, CA 95116
P: (408) 984-7226
F: (408)-708-4454
NPI: 1083720304
Ultrasound, Digital
Mammography

CONCORD
1401 Willowpass Rd., #110
Concord, CA 94520
P: (925) 691-6432
F: (925) 691-6434
Open MRI, X-ray, Ultrasound
Digital Mammography,
MR Arthrography