



Piedmont Imaging
PiedmontImaging.com

684 N. Pine Street, Spartanburg, SC 29303
Tax ID: 58-2324016
Phone: 864.542.0033 • Fax: 864.542.0025

Patient's name: _____ DOB: _____

Mobile #: _____ Alternate #: _____ Insurance: _____

Appointment date: _____ Appointment time: _____ Authorization: _____

☐ Call patient to schedule

**Please call when
scheduling all STAT exams**

MRI	CT	ULTRASOUND	X-RAY
CONTRAST <input type="radio"/> Radiologist Discretion <input type="radio"/> W/O <input type="radio"/> W/ & W/O <input type="radio"/> Brain <input type="radio"/> C-spine <input type="radio"/> L-spine <input type="radio"/> T-spine <input type="radio"/> Shoulder <input type="radio"/> R <input type="radio"/> L <input type="radio"/> Ankle <input type="radio"/> R <input type="radio"/> L <input type="radio"/> Foot <input type="radio"/> R <input type="radio"/> L <input type="radio"/> Knee <input type="radio"/> R <input type="radio"/> L <input type="radio"/> MRA: _____ <input type="radio"/> Other: _____	CONTRAST <input type="radio"/> Radiologist Discretion <input type="radio"/> W/ <input type="radio"/> W/O <input type="radio"/> Brain <input type="radio"/> Orbit <input type="radio"/> Paranasal Sinus <input type="radio"/> Paranasal Sinus Stereotactic Protocol: _____ <input type="radio"/> Temporal Bones <input type="radio"/> Facial Bones <input type="radio"/> Soft Tissue Neck <input type="radio"/> Chest <input type="radio"/> Abdomen <input type="radio"/> Pelvis <input type="radio"/> Abdomen & Pelvis <input type="radio"/> Abd/Pelvis Stone Protocol <input type="radio"/> C-spine <input type="radio"/> L-spine <input type="radio"/> T-spine <input type="radio"/> Other: _____ <input type="radio"/> Dedicated Studies <input type="checkbox"/> Adrenal <input type="checkbox"/> Liver-Triple Phase <input type="checkbox"/> Pancreas <input type="checkbox"/> Renal-Triple Phase	<input type="radio"/> Abdomen <input type="radio"/> Limited Abdomen <input type="radio"/> Gallbladder <input type="radio"/> Renal (Kidneys & Bladder) <input type="radio"/> Aorta <input type="radio"/> Pelvic Complete <input type="radio"/> Transvaginal Pelvic <input type="radio"/> Pelvic with Transvaginal <input type="radio"/> Carotid Studies <input type="radio"/> Arterial Scan <input type="checkbox"/> Unilat <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilat <input type="checkbox"/> ~ Upper Extremity (arms) <input type="checkbox"/> Lower Extremity (legs) <input type="radio"/> Venous Scan <input type="checkbox"/> Unilat <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilat <input type="checkbox"/> Upper Extremity (arms) <input type="checkbox"/> Lower Extremity (legs) <input type="radio"/> OB <input type="radio"/> Thyroid <input type="radio"/> Scrotum <input type="radio"/> Soft Tissue <input type="checkbox"/> Specify: _____ <input type="radio"/> Musculoskeletal <input type="checkbox"/> Specify: _____ <input type="radio"/> Other: _____	Please specify: <input type="radio"/> Cervical <input type="radio"/> Thoracic <input type="radio"/> Lumbar <input type="radio"/> Chest <input type="radio"/> Hip <input type="radio"/> R <input type="radio"/> L <input type="radio"/> Knee <input type="radio"/> R <input type="radio"/> L <input type="radio"/> Other: _____ COMPARISON STUDIES Date of service: _____ Location: _____ Type of study: _____ REPORT DELIVERY <input type="radio"/> STAT Fax Fax#: _____ <input type="radio"/> Call Report Cell or backline #: _____ Standard Report in 24-48 hours. IMAGE DELIVERY <input type="radio"/> Send CD with patient
SCREENING <input type="radio"/> Cardiac Score			
IMPLANT <input type="radio"/> Pacemaker (no MRI) <input type="radio"/> Neurostimulator <input type="radio"/> Other: Brand: _____ Serial #: _____			

Insurance (Please fax front and back of patient's card and any clinical information to 864.542.0025)

Clinical indications/Signs/Symptoms: _____

ICD-10 Code(s): _____

Provider name (printed): _____ Provider signature: _____

Office phone: _____ Fax: _____ Date: _____

NOTE: CAREFULLY FOLLOW EXAM PREPARATION INSTRUCTIONS ON THE BACK SIDE OF THIS FORM

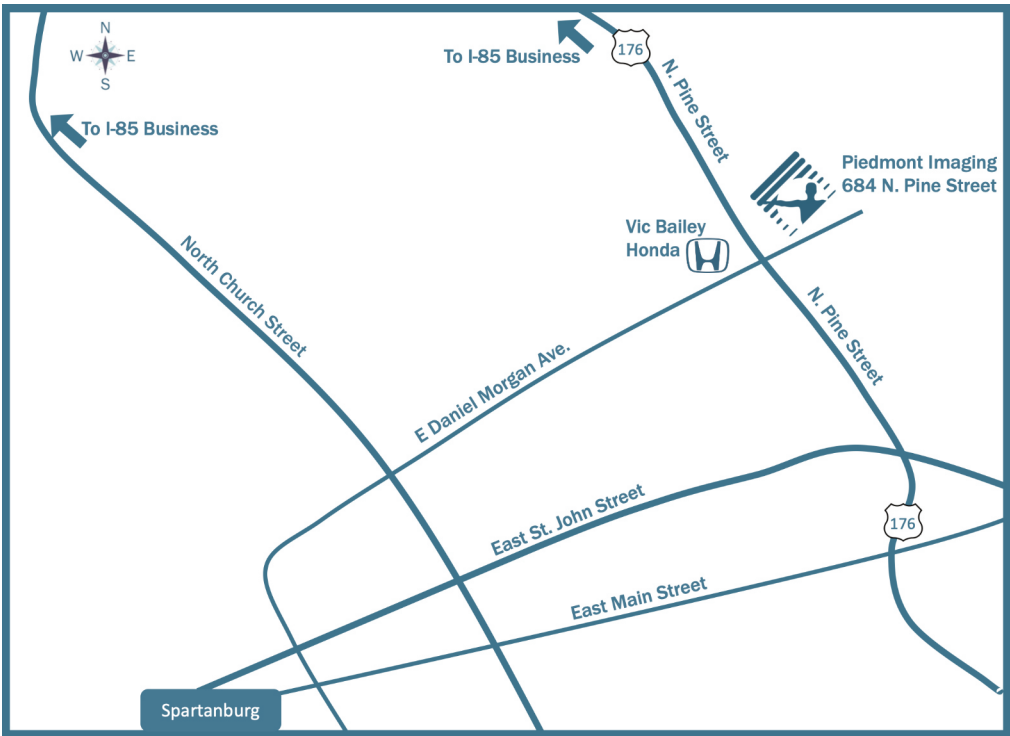
REV: 02.06.2023

PATIENT INSTRUCTIONS

BRING THIS ORDER WITH YOU TO YOUR SCHEDULED EXAM

VISIT US ONLINE AT PIEDMONTIMAGING.COM FOR DRIVING DIRECTIONS AND TO LEARN MORE ABOUT OUR IMAGING FACILITY AND SERVICES.

Our Location



Piedmont Imaging
684 N. Pine Street
Spartanburg, SC 29303
Phone: 864.542.0033
Fax: 864.542.0025

MRI (Magnetic Resonance Imaging)

Our office will contact you 24 hours before your appointment to confirm your appointment and provide prep instructions.

Do not wear eye makeup or mascara for ANY Brain & Neck studies. Do not wear any jewelry or hairpins. Wear comfortable clothing.

Let us know if you have:

- Metallic fragments in your eyes or previous injury to the eye involving a metal object
- Any type of implanted mechanical pump
- Any type of surgery within the past 8 weeks
- A history of cancer
- A pacemaker/ defibrillator/ stimulator
- An aneurysm clip
- Any metallic/ electronic implant

Let us know if you are:

- Allergic to CT or MRI contrast
- Claustrophobic
- Pregnant/Nursing
- In need of special assistance

Ultrasound

Abdomen, Right Upper Quadrant, Renal, Aorta:

- Nothing to eat or drink after midnight or 8 hours prior to exam.

Renal or Transabdominal Pelvic

- Full bladder required. All must drink 32 oz. of water 1 hour prior to exam (if on a fluid restricted diet, please contact the office for other instructions).

CT (Computed Tomography)

Our office will contact you 24 hours before your appointment to confirm your appointment and provide prep instructions.



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MRI | Open MRI | CT | X-ray | Ultrasound
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