HAWAII RADIOLOGIC ASSOCIATES, LTD.

IMAGING CENTER

☐ **HILO OFFICE:**	670 Ponahawai St. #110	Hilo, HI 96720	Phone: (808) 933-2540	Fax: (808) 935-5207
☐ **KINOOLE OFFICE:**	1248 Kinoole St. #105	Hilo, HI 96720	Phone: (808) 935-7999	Fax: (808) 933-1227

(**Patients**) Last Name	First Name	Middle Initial	Date of Birth	Age	Sex ☐ M ☐ F	Date of Exam
(**Guarantors**) Last Name	First Name	Middle Initial	**Known Allergies:**			Appt Time
Address			Date of Injury / Pregnancy (LMP)		Injury type: ☐ Work ☐ Auto ☐ Other	
City	State	Zip	Description of Injury			
Home Phone:	Work Phone:		Stat Report ☐ Phone Report ☐ Fax Report Fax Number:_____			
Primary Insurance :	Secondary Insurance:		Please check one: ☐ Patient to Wait ☐ Patient return with film and report ☐ Patient may leave			
			Exam(s) not listed below:			
Clinical Information			**ICD9:**			
Referring Physician Signature X		Date	**Cc:**	**Cc:**		**Cc:**

XRAY – ULTRASOUND – CT EXAMINATIONS

HEAD / NECK			***SPINE (CONTINUED)***			LOWER EXTREMITIES (CONTINUED)			***CT***	
SINUSES COMPLETE			THORACIC SPINE COMPLETE			KNEE 4 VIEWS (SUNRISE)	R	L	CT HEAD	
FACIAL BONES COMPLETE			LUMBAR SPINE COMPLETE			LOWER LEG (TIB-FIB)	R	L	CT ORBITS	
ORBITS			LUMBAR SPINE COMPLETE + BENDING			ANKLE 3 VIEWS	R	L	CT IAC	
NASAL BONES			PELVIS			FOOT 3 VIEWS	R	L	CT TEMPORAL BONES	
SOFT TISSUE NECK			SACRUM + COCCYX			CALCANEUS	R	L	CT MAXILLOFACIAL	
MANDIBLE COMPLETE			SCOLIOSIS PA + LAT			TOES	R	L	CT SINUSES	
SKULL COMPLETE			SCOLIOSIS PA			BONE LENGTH			CT NECK SOFT TISSUE	
TMJ BILATERAL			SI JOINTS BILATERAL			***ABDOMEN***			CT CHEST	
CHEST/RIBS			UPPER EXTREMITIES			KUB			CT CERVICAL SPINE	
CHEST 2 VIEWS			CLAVICLE	R	L	ABDOMEN 2 VIEWS			CT THORACIC SPINE	
CHEST 1 VIEW			SCAPULA	R	L	ACUTE ABDOMINAL SERIES			CT LUMBAR SPINE	
CHEST SPECIAL VIEWS			SHOULDER	R	L	***GENITOURINARY***			CT SPIRAL KUB	
RIBS UNI 2 VIEWS	R	L	AC JOINTS			IVP + TOMOGRAMS			CT ABDOMEN (ROUTINE)	
RIBS UNI + PA CXR	R	L	HUMERUS	R	L	***ULTRASOUND***			CT ABDOMEN + PELVIS (ROUTINE)	
STERNUM			ELBOW COMPLETE	R	L	NECK (THYROID)			CT PELVIS (ROUTINE)	
STERNOCLAVICULAR JOINTS			FOREARM	R	L	ABDOMEN COMPLETE			CT HEMATURIA PROTOCOL	
GASTROINTESTINAL			WRIST COMPLETE	R	L	LIVER + DOPPLER			CT PELVIS (APPENDIX PROTOCOL)	
ESOPHAGUS			HAND COMPLETE	R	L	RENAL				
UGI AIR CONTRAST (AC)			FINGERS	R	L	AORTA				
UGI AIR CONTRAST W/SBFT			BONE AGE (SINGLE VIEW HAND)			OB COMPLETE				
T-TUBE CHOLANGIOGRAM			LOWER EXTREMITIES			FETAL BIOPHYSICAL PROFILE				
SBFT (SMALL BOWEL STUDY)			HIPS COMPLETE	R	L	PELVIC ROUTINE				
BE AIR CONTRAST			PELVIS/HIPS INFANT			PELVIC (TRANSABDOMINAL ONLY)				
SPINE			FEMUR	R	L	CAROTID ULTRASOUND				
CERVICAL SPINE LIMITED 2 VIEWS			KNEE AP BILAT STANDING 1 VIEW			NONINVASIVE EXTREMITY VENOUS (DVT)	R	L		
CERVICAL COMPLETE			KNEE 2 VIEWS	R	L	SCROTUM				
CERVICAL SPINE COMP + FLEX/EXT			KNEE 3 VIEWS (ROUTINE)	R	L	BLADDER W/POST VOID RESIDUAL				

CT & MRI EXAMS

Note: Use of IV contrast shall be left to the discretion of the radiologist. If you DO NOT want IV contrast material used, please check here: ☐

IV CONTRAST

KIDNEY PROBLEMS?
☐ YES ☐ NO

IF YES:
CURRENT CREATININE LEVEL: _____
DATE: _____

MRI EXAMINATIONS

HEAD	√	***SPINE***	√	***JOINT / EXTREMITY (CONTINUED)***	√	***MISC***	
BRAIN		CERVICAL SPINE		ANKLE		SOFT TISSUE NECK	
BRAIN + MR ANGIOGRAPHY		THORACIC SPINE		FOOT		BREAST ROUTINE	
CAROTID MR ANGIOGRAPHY		LUMBAR SPINE		SOFT TISSUE OR BONE MASS		BREAST FOR IMPLANTS	
IAC		SPINE FOR METASTASES		***ABDOMEN***		FEMALE PELVIS	
BRAIN – ATTN. POST. FOSSA		***JOINT / EXTREMITY***	√	ABDOMEN (GENERAL STUDY)		BRACHIAL PLEXUS	
BRAIN FOR SEIZURES		SHOULDER		LIVER			
BRAIN FOR MULTIPLE SCLEROSIS		ARTHROGRAM SHOULDER		MR CHOLANGIOPANCREATOGRAPHY (MRCP)			
BRAIN FOR TUMOR/METASTASES		ELBOW		PANCREAS			
PITUITARY		WRIST		KIDNEYS			
ORBITS		ARTHROGRAM WRIST		RENAL MR ANGIOGRAPHY			
		HIPS/PELVIC BONE		ADRENALS			
		KNEE					

HISTORY OF SURGERY	☐ NO	☐ YES	DATE:	AREA:	
COMPARISON STUDIES	☐ NO	☐ YES If YES, Select:	☐ MRI ☐ CT ☐ X-RAY	☐ ULTRASOUND	☐ NUCLEAR MEDICINE
LOCATION AND DATE OF PREVIOUS STUDIES, IF KNOWN:					

DOES THE PATIENT HAVE A CARDIAC PACEMAKER?	☐ YES	☐ NO	DOES THE PATIENT HAVE A BIOSTIMULATOR IMPLANT	☐ YES	☐ NO
HAS THE PATIENT EVER HAD SURGERY FOR AN ANEURYSM?	☐ YES	☐ NO	IS THE PATIENT PREGNANT? IF YES, HOW MANY WEEKS? _____	☐ YES	☐ NO
HAS THE PATIENT EVER HAD BRAIN SUGERY?	☐ YES	☐ NO	HAS THE PATIENT EVER HAD METAL DEBRIS IN HIS/HER EYES?	☐ YES	☐ NO
HAS THE PATIENT EVER HAD HEART SURGERY?	☐ YES	☐ NO	IS THE PATIENT CLAUSTROPHOBIC?	☐ YES	☐ NO

SPECIAL INSTRUCTIONS AND PREP:

TECHNOLOGIST NOTES:

CONSENT TO USE AND DISCLOSE
PROTECTED HEALTH INFORMATION

I hereby give my consent to HAWAII RADIOLOGIC ASSOCIATES, LTD. ("HRA"), to release and disclose my medical information, reports, and records compiled, produced, or created by HRA with respect to radiology and other services performed by HRA (collectively, the "Medical Records"): (a) to any health plan or health insurer, including, but not limited to, third party payors, workers' compensation and no-fault insurance carriers, that provide any health care coverage or similar insurance coverage to me, for any purpose related to payment of HRA's charges; (b) to any insurance company that provides professional liability insurance to HRA to evaluate clinical performance; (c) pursuant to any subpoena or other legal process or as otherwise required by law; (d) to any provider that is federally mandated under the Mammography Quality Standards Act of 1992, as amended; and (e) to the provider or entity who referred me to HRA for radiology services for my continued treatment.

- ❖ I understand that by this consent protected health information may be used and disclosed to carry out treatment, payment or health care operations.
- ❖ I acknowledge that I have been provided with a *Notice of Privacy Practices* (the "Notice") by HRA which provides a more complete description of how protected health information may be used or disclosed by HRA. I understand that I have the right to review the Notice prior to signing this consent. I also understand that HRA may change its privacy practices described in the Notice and will mail a copy of any revised notice to me prior to implementation at the address I have provided.
- ❖ I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations. I also understand that HRA is not required to agree to the requested restrictions, but if HRA does agree to the requested restrictions, it will be bound by them.
- ❖ I understand that I may revoke this authorization at any time by providing written notification to HRA, and that such revocation will not affect any actions taken by HRA before it received my written notification.

☐ I request the following restrictions to the use or disclosure of my health information.

_____

_____

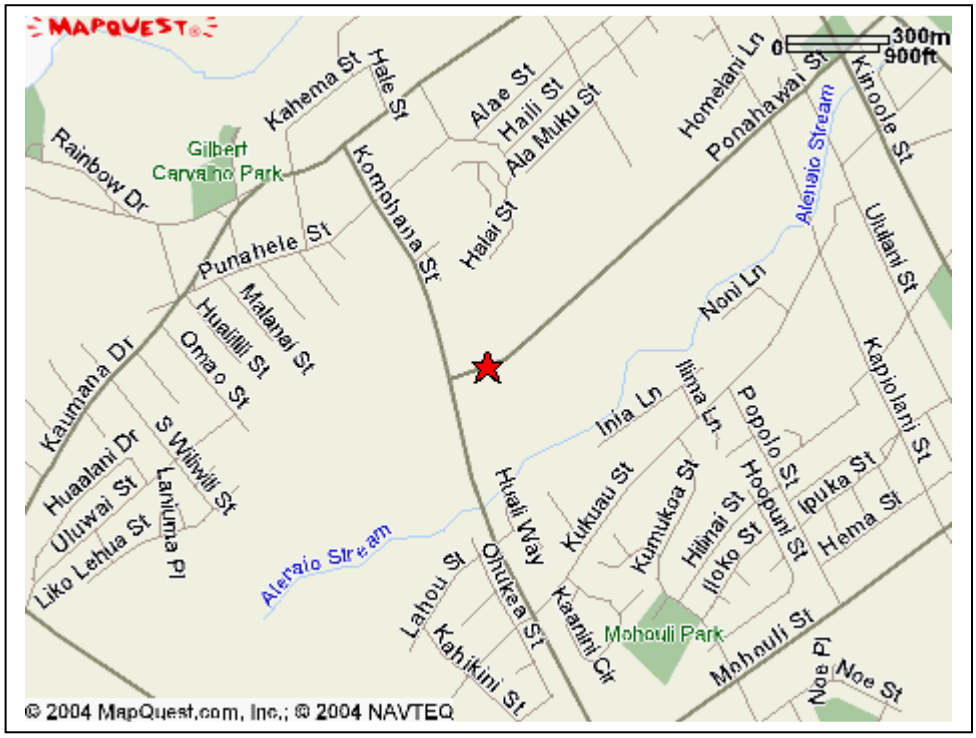
_____ _____
Name of Patient *Patient's Social Security Number*

_____
Signature of Patient or Patient's Representative *Date*

Name of Patient's Representative: _____

Relationship to Patient: _____

Mailing Address of Patient or Patient's Representative: _____



SNF STAMP: