

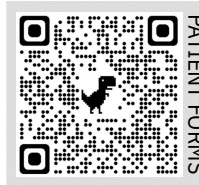
Mission Viejo

27401 Los Altos, Suite 180
Mission Viejo, CA 92691
P: 949-367-1010 F: 949-367-1011
crownvalleyimaging.com
1.5T MRI | CT | US | X-RAY | DEXA



Crown Valley


IMAGING



PATIENT FORMS

Newport Beach/Irvine
4501 Birch Street, Suite C
Newport Beach, CA 92660
P: 949-367-1010 F: 949-367-1011
crownvalleyimaging.com
3 Tesla MRI

FAX TO 949-367-1011 | E-MAIL TO SCHEDULING@CVIMAGING.NET

First Name			Urgency	<input type="checkbox"/> STAT <input type="checkbox"/> ASAP <input type="checkbox"/> Routine	Renal function for contrast studies:
Last Name			Provider Fax #		
DOB		<input type="checkbox"/> M <input type="checkbox"/> F	Provider Phone #		CT
Patient Phone			CC Physician:		MRI
Date / /			AUTHORIZATION: If referring provider has obtained authorization, please attach. <input type="checkbox"/> NAN <input type="checkbox"/> To be done by CVI <input type="checkbox"/> Obtained; see attached. Auth Expire Date: Insurance: Reference #:		GFR Cutoff is 30. Any Renal Disease or Diabetes  <input type="checkbox"/> Cr within 90 days attached <input type="checkbox"/> Cr to be done at CVI
History/ Diagnostic/ ICD:					Gadolinium is NOT nephrotoxic. We use Gadavist which could be used even in dialysis patients. Per ACR guidelines, routine renal function screening is NOT recommended with Gadavist.
Physician Name	Signature				

MRI

NEURO	SPINE	MR ANGIOGRAPHY	ABDOMEN/PELVIS	MUSCULOSKELETAL
Brain <input type="checkbox"/> w <input type="checkbox"/> wo <input type="checkbox"/> + Orbit w/wo <input type="checkbox"/> + IAC w/wo <input type="checkbox"/> + Pituitary (w/wo) <input type="checkbox"/> + Neuro Quant <input type="checkbox"/> + DTI <input type="checkbox"/> Face/Sinus w/wo <input type="checkbox"/> Neck w/wo <input type="checkbox"/> Brachial Plexus wo <input type="checkbox"/> TMJ wo	<input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Sacral <input type="checkbox"/> wo (Pain/Trauma) <input type="checkbox"/> wwo (Infection/Tumor) Comments/custom orders:	<input type="checkbox"/> Angiography <input type="checkbox"/> Venography <input type="checkbox"/> WO <input type="checkbox"/> W/WO <input type="checkbox"/> Brain <input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Abd/Pelvis (2 exams) <input type="checkbox"/> Runoff	<input type="checkbox"/> Abdomen w/wo <input type="checkbox"/> Eovist <input type="checkbox"/> MRCP wo <input type="checkbox"/> Liver Iron Quant <input type="checkbox"/> Enterography w/wo +oral <input type="checkbox"/> Female Pelvis w/wo <input type="checkbox"/> Bony Pelvis wo <input type="checkbox"/> Multiparametric Prostate w/wo	<input type="checkbox"/> Shoulder R L <input type="checkbox"/> Humerus R L <input type="checkbox"/> Elbow R L <input type="checkbox"/> Wrist R L <input type="checkbox"/> Hand R L <input type="checkbox"/> Hip R L <input type="checkbox"/> Femur R L <input type="checkbox"/> Knee R L <input type="checkbox"/> Tibia/Fib R L <input type="checkbox"/> Ankle R L <input type="checkbox"/> Foot R L <input type="checkbox"/> w/o (Pain, Trauma) <input type="checkbox"/> w/wo IV contrast (Infection/Tumor) <input type="checkbox"/> Arthrogram <input type="checkbox"/> 1.5T Mission Viejo <input type="checkbox"/> 3T Newport Beach

CT

NEURO	SPINE	CT ANGIOGRAPHY	ABD/PELVIS/CHEST	MUSCULOSKELETAL
<input type="checkbox"/> Head wo <input type="checkbox"/> Head w/wo <input type="checkbox"/> Temporal Bone wo <input type="checkbox"/> Maxillofacial wo <input type="checkbox"/> Sinus wo <input type="checkbox"/> Neck w or wo <input type="checkbox"/> 4D Parathyroid w/wo W OR WO REFERS TO IV CONTRAST ONLY.	<input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Sacral <input type="checkbox"/> wo (Pain/Trauma) <input type="checkbox"/> w (Infection/Tumor) <input type="checkbox"/> Myelogram Comments/custom orders:	<input type="checkbox"/> Angiography <input type="checkbox"/> Venography <input type="checkbox"/> Brain <input type="checkbox"/> Neck <input type="checkbox"/> Pelvis <input type="checkbox"/> Runoff <input type="checkbox"/> Chest <input type="checkbox"/> Abd <input type="checkbox"/> If dissection or endoleak: w/wo <input type="checkbox"/> Chest PE *Contrast required for all angiography.	<input type="checkbox"/> A/P <input type="checkbox"/> Oral <input type="checkbox"/> A/P WO (Kidney Stone) <input type="checkbox"/> Liver 3-Phase w <input type="checkbox"/> Kidney Stone low dose <input type="checkbox"/> Urogram w/wo <input type="checkbox"/> Enterography w +po CHEST <input type="checkbox"/> wo (nodule, PNA) <input type="checkbox"/> w (CA staging, etc.) <input type="checkbox"/> Low Dose screening <input type="checkbox"/> High Res Chest (ILD) <input type="checkbox"/> Coronary CA Score	<input type="checkbox"/> Shoulder R L <input type="checkbox"/> Humerus R L <input type="checkbox"/> Elbow R L <input type="checkbox"/> Wrist R L <input type="checkbox"/> Hand R L <input type="checkbox"/> Hip R L <input type="checkbox"/> Femur R L <input type="checkbox"/> Knee R L <input type="checkbox"/> Tibia/Fib R L <input type="checkbox"/> Ankle R L <input type="checkbox"/> Foot R L <input type="checkbox"/> w/o (Pain, Trauma) <input type="checkbox"/> w IV contrast (Infection/Tumor) <input type="checkbox"/> Arthrogram 64-Slice GE with High- Resolution Thin Sections and LOW Dose ASiR technology

US

<input type="checkbox"/> Abdomen Complete <input type="checkbox"/> RUQ <input type="checkbox"/> Renal <input type="checkbox"/> Renal Artery Doppler <input type="checkbox"/> Bladder +PVR	<input type="checkbox"/> Aorta <input type="checkbox"/> Pelvis w Transvaginal <input type="checkbox"/> Pelvis wo Transvaginal <input type="checkbox"/> OB < 14 weeks <input type="checkbox"/> Scrotum	<input type="checkbox"/> Soft Tissue: Area of interest (No Appendix US) <input type="checkbox"/> Thyroid <input type="checkbox"/> Carotid	<input type="checkbox"/> DVT Lower Extremity R L BL <input type="checkbox"/> DVT Upper Extremity R L BL <input type="checkbox"/> Arterial Lower Extremity R L BL <input type="checkbox"/> Arterial Upper Extremity R L BL
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X-RAY

<input type="checkbox"/> Cervical Spine <input type="checkbox"/> 2 View (AP/Lat) <input type="checkbox"/> 5 View(+ Obliques) <input type="checkbox"/> 7 View(+ Flex/Ext) <input type="checkbox"/> Thoracic Spine 2 View	<input type="checkbox"/> Lumbar Spine <input type="checkbox"/> 2 View (AP/Lat) <input type="checkbox"/> 5 View(+ Obliques) <input type="checkbox"/> 7 View(+ Flex/Ext) <input type="checkbox"/> SI Joints	<table border="1"> <tr><td>Shoulder</td><td>R</td><td>L</td></tr> <tr><td>Humerus</td><td>R</td><td>L</td></tr> <tr><td>Elbow</td><td>R</td><td>L</td></tr> <tr><td>Forearm</td><td>R</td><td>L</td></tr> <tr><td>Wrist</td><td>R</td><td>L</td></tr> <tr><td>Scaphoid</td><td>R</td><td>L</td></tr> <tr><td>Hand</td><td>R</td><td>L</td></tr> </table>	Shoulder	R	L	Humerus	R	L	Elbow	R	L	Forearm	R	L	Wrist	R	L	Scaphoid	R	L	Hand	R	L	<table border="1"> <tr><td>Pelvis</td><td></td></tr> <tr><td>Hip</td><td>R L</td></tr> <tr><td>Femur</td><td>R L</td></tr> <tr><td>Knee</td><td>R L</td></tr> <tr><td>Tibia/Fib</td><td>R L</td></tr> <tr><td>Ankle</td><td>R L</td></tr> <tr><td>Foot</td><td>R L</td></tr> </table>	Pelvis		Hip	R L	Femur	R L	Knee	R L	Tibia/Fib	R L	Ankle	R L	Foot	R L	<input type="checkbox"/> Chest (PA/LAT) <input type="checkbox"/> Rib Series R L <input type="checkbox"/> KUB <input type="checkbox"/> Neck (2 View) <input type="checkbox"/> Skull (2 View) <input type="checkbox"/> Sinus (Complete) <input type="checkbox"/> Sinus (Water View)	<input type="checkbox"/> Bone Density <input type="checkbox"/> Whole Body Composition: Whole body muscle mass, body fat and bone density measurement.
Shoulder	R	L																																						
Humerus	R	L																																						
Elbow	R	L																																						
Forearm	R	L																																						
Wrist	R	L																																						
Scaphoid	R	L																																						
Hand	R	L																																						
Pelvis																																								
Hip	R L																																							
Femur	R L																																							
Knee	R L																																							
Tibia/Fib	R L																																							
Ankle	R L																																							
Foot	R L																																							
Weight Bearing?: <input type="checkbox"/> YES <input type="checkbox"/> NO *If ordering multiple XR exams, please specify which exams need to be weight bearing.																																								
OTHER X-RAY/ ADDITIONAL NOTES:																																								

DEXA

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GOOGLE DIRECTIONS



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Newport Beach (Bordering Irvine)

4501 Birch Street, Suite C
Newport Beach, CA 92660
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3 Tesla MRI

Heading South on 5

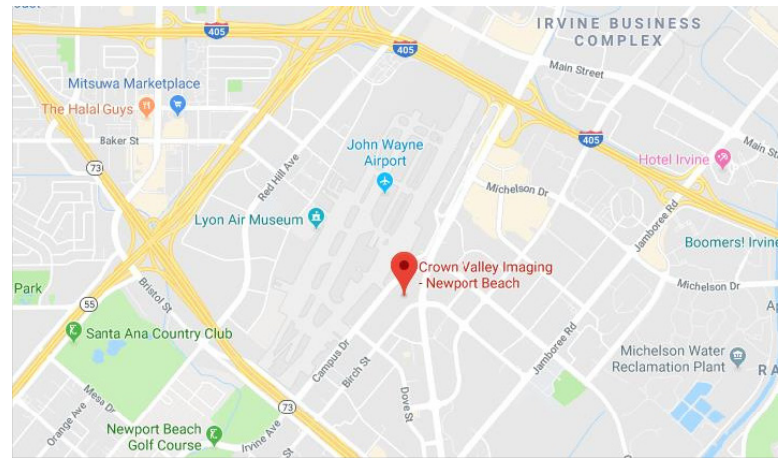
Exit LEFT on Crown Valley Pkwy Turn Left on Los Altos. Turn LEFT into the second driveway.

Heading North on 5

Exit RIGHT on Crown Valley Pkwy Turn Left on Los Altos. Turn LEFT in the second driveway.

From PCH

Head East (Inland) on Crown Valley Pkwy; cross over 5 freeway. Turn LEFT on Los Altos. Turn LEFT into the second driveway.



Heading North on 405

Exit LEFT on MacArthur Blvd.

Turn RIGHT on Birch St. Turn RIGHT into 4501 Birch.

Heading North on 73

Exit on Birch. Turn RIGHT on Birch.

Building on LEFT hand side before MacArthur.

Heading South on 405 to 73 South (NO TOLL)

Exit Straight on SE Bristol St./ Irvine Ave. Turn LEFT on Birch St.

Turn LEFT into 4501 Birch St.

Heading South on 405

Exit RIGHT on MacArthur Blvd. Turn RIGHT on Birch St. Turn

RIGHT into 4501 Birch St.

FOR ALL EXAMINATIONS

If possible, dress in loose, comfortable two-piece clothing. No belts, buckles or zippers. Please arrive 20 minutes prior to your appointment time. Bring your insurance card and picture ID with you to your appointment. Follow the QR code to the right to fill out patient forms prior to appointment.



PATIENT FORMS

CT

- If your exam requires IV Contrast, DO NOT eat or drink anything other than water and your medications for 4 hours prior to your appointment time.
- If you have an allergy to CT Contrast, please notify the scheduler.

MRI

- If your exam requires Oral Contrast, please come by our office at least 1 day prior to your exam to pick it up along with instructions.
- Please notify the scheduler if you have ANY hardware or implanted devices. Some examples: Cardiac Pacemaker or Defibrillator, Aneurysm Clips, Metal in Eyes (Metal Workers), Cochlear Implants, Pain pumps and stimulators.
- If Claustrophobic please notify the scheduler.

US

- Pelvic or Renal studies: Drink as much as water you think it's necessary for a full bladder. Do not drink too much water.
- Abdominal Study: No food for 6 hours. Water and medications are okay.