Riceland
DIAGNOSTIC IMAGING CENTER™

390 N, 11th Street
Beaumont, TX 77702
Imaging Direct: (409) 981-5500
Imaging Scheduling Ext. 1823
Imaging Insurance Ext. 1821
Fax: (409) 974-7371

REFERRAL FORM

FOR **STAT ORDERS PLEASE CHECK HERE→ ☐ → THEN CALL OFFICE AT (409) 981-5500**

Patient Name ______________________ DOB __________

Patient Phone (Primary) ______________________ Phone (alternate) __________

Referring Physician ______________________ Office Phone __________

Diagnosis / ICD 10 ______________________

Insurance Carrier ______________________ Authorization # __________

REQUIREMENT FOR ALL CONTRAST EXAM

Bun and creatinine Labs required for ANYONE:

- Age 60 years or older
- With Diabetes, regardless of age or DM type
- Being medically treated for Hypertension (i.e. taking medication), regardless of age

- Labs must have been done within last 30 days
- Labs results should be received prior to exam
- Creatinine I-stat available at center if not already done

*Previous CT/ MRI: ☐Y ☐ N | Where: __________

☐ MRI		☐ CT	
☐ W/O I.V. Contrast	☐ With I.V. Contrast	☐ W/O I.V. Contrast	☐ With I.V. Contrast
☐ W & W/O I.V. Contrast		☐ W & W/O I.V. Contrast	☐ Other: ______
MRI BRAIN		**CT BRAIN**	
☐ Brain	☐ Maxillo-Facial	☐ Brain	☐ Maxillo-Facial
☐ IAC's/ Temporal	☐ Orbits	☐ Temporal Bones	☐ Orbits
☐ Sinuses	☐ Sella/ Pitultary	☐ Sinuses	☐ Other: ______
MRI BODY	**MRI SPINE**	**CT BODY**	**CT SPINE**
☐ Neck	☐ Cervical	☐ Neck	☐ Cervical
☐ Pelvis	☐ Thoracic	☐ Chest	☐ Thoracic
-	☐ Lumbar	☐ Abdomen ☐ Pelvis	☐ Lumbar
MRI Angiogram		**CT Angiogram**	
☐ Circel of Willis (Brain)	☐ Other: ______	☐ Area: ______	☐ Other: ______
MRI		**CT**	
☐ L Shoulder	☐ R Shoulder	☐ L Shoulder	☐ R Shoulder
☐ L Humerus (Arm)	☐ R Humerus (Arm)	☐ L Humerus (Arm)	☐ R Humerus (Arm)
☐ L Elbow	☐ R Elbow	☐ L Elbow	☐ R Elbow
☐ L Forearm	☐ R Forearm	☐ L Forearm	☐ R Forearm
☐ L Wrist	☐ R Wrist	☐ L Wrist	☐ R Wrist
☐ L Hand	☐ R Hand	☐ L Hand	☐ R Hand
☐ L Hip	☐ R Hip	☐ L Hip	☐ R Hip
☐ L Femur (Thigh)	☐ R Femur (Thigh)	☐ L Femur (Thigh)	☐ R Femur (Thigh)
☐ L Knee	☐ R Knee	☐ L Knee	☐ R Knee
☐ L Tibia/ Fibula	☐ R Tibia/ Fibula	☐ L Tibia/ Fibula	☐ R Tibia/ Fibula
☐ L Ankle	☐ R Ankle	☐ L Ankle	☐ R Ankle
☐ L Foot	☐ R Foot	☐ L Foot	☐ R Foot
MRI Other: ______		CT Other: ______	

Physician Name: ______________________ **Date Ordered:** __________

Physician Signature: ______________________