



IMAGING CENTER AT CYPRESS

9300 E 29th St N, Suite 207

Wichita, KS 67226

(316) 858-5200 Fax (316) 858-5204

Name: _____ Date of Birth _____

Referring Physician _____

Reason for Exam: _____

Renal History _____

- | | |
|--|---|
| <input type="checkbox"/> Breast Bilateral
<input type="checkbox"/> Implant Protocol | <input type="checkbox"/> Ankle Right / Left |
| <input type="checkbox"/> Brain without contrast
<input type="checkbox"/> Brain with & without contrast
<input type="checkbox"/> IAC
<input type="checkbox"/> Pituitary | <input type="checkbox"/> Elbow Right / Left
<input type="checkbox"/> Arthrography |
| <input type="checkbox"/> Cervical Spine without contrast
<input type="checkbox"/> with & without contrast | <input type="checkbox"/> Knee Right / Left |
| <input type="checkbox"/> Lumbar Spine
<input type="checkbox"/> with & without contrast | <input type="checkbox"/> Shoulder Right / Left
<input type="checkbox"/> Arthrography |
| <input type="checkbox"/> Thoracic Spine
<input type="checkbox"/> with & without contrast | <input type="checkbox"/> Abdomen
<input type="checkbox"/> with & without contrast |
| | <input type="checkbox"/> Pelvis without contrast
<input type="checkbox"/> with & without contrast |

Other _____

Please let our staff know if you have a pacemaker, brain aneurysm clip or have done grinding, riveting or welding on metal. It is possible that an x-ray will need to be taken prior to your MRI to ensure no metal is present in either eye.