



STAR Imaging

Fax order to
614.424.9112
 For questions, please call
614.358.4223

Appointment Date/Time

Appointment Location

____ Kenny Road
 ____ Jasonway Avenue
 ____ Beecher Road

PATIENT INFORMATION: Please also attach patient's insurance and demographic information.

Name	Referring Physician
Home Phone/Mobile Phone	Office Contact/Phone
Patient Weight/Height	Office Fax
DOB	Provider Signature (required)
SS#	Date (required)

Diagnosis/ICD-10 _____

Signs and Symptoms/Reason for Exam _____

EXAM INFORMATION

*Not all procedures are performed at all locations.

MRI	Nuclear Medicine	CT	PET/CT
Contrast: <input type="radio"/> With/Without <input type="radio"/> Radiologist decision <input type="radio"/> Without SPINE <input type="radio"/> Cervical <input type="radio"/> Coccyx/ Sacrum <input type="radio"/> Thoracic <input type="radio"/> Lumbar MUSCULOSKELETAL <input type="radio"/> Boney Pelvis LOWER <input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Femur <input type="radio"/> Hip <input type="radio"/> Knee <input type="radio"/> Tib/Fib <input type="radio"/> Ankle (hindfoot) <input type="radio"/> Foot (forefoot) UPPER <input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Forearm <input type="radio"/> Elbow <input type="radio"/> Humerus <input type="radio"/> Shoulder <input type="radio"/> Wrist <input type="radio"/> Hand	BONE <input type="radio"/> Whole body bone scan <input type="radio"/> Limited bone scan <input type="radio"/> Bone Marrow <input type="radio"/> SPECT <input type="radio"/> Three phase <input type="radio"/> CERETEC WBC <input type="radio"/> INDIUM WBC <input type="radio"/> GALLIUM <input type="radio"/> GASTRIC EMPTYING <input type="radio"/> HEMANGIOMA HEPATOBIILIARY (PIPIDA - HIDA) <input type="radio"/> With EF <input type="radio"/> Without EF <input type="radio"/> LIVER/SPLEEN <input type="radio"/> MIBG <input type="radio"/> MUGA (RESTING) <input type="radio"/> SPECT BRAIN <input type="radio"/> PROSTASCINT RENAL <input type="radio"/> Captropril <input type="radio"/> Lasix <input type="radio"/> Non RPh THYROID <input type="radio"/> Uptake and Scan <input type="radio"/> Uptake only <input type="radio"/> Parathyroid Bone Densitometry <input type="radio"/> DEXA	Contrast: <input type="radio"/> With <input type="radio"/> Without <input type="radio"/> Radiologist decision <input type="radio"/> Head <input type="radio"/> Facial Bones/Orbits <input type="radio"/> Temporal Bones/IACS/Mastoids <input type="radio"/> Sinus - Maxillofacial <input type="radio"/> Neck Soft Tissue <input type="radio"/> Chest/Mediastinum <input type="radio"/> Abdomen <input type="radio"/> Abdomen/Pelvis <input type="radio"/> Pelvis <input type="radio"/> Urography <input type="radio"/> Enterography <input type="radio"/> Stone Protocol Spine <input type="radio"/> Cervical <input type="radio"/> Thoracic <input type="radio"/> Lumbar Extremity <input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Ankle <input type="radio"/> Foot <input type="radio"/> Knee <input type="radio"/> Shoulder <input type="radio"/> Wrist <input type="radio"/> Hand <input type="radio"/> Elbow <input type="radio"/> Other	<input type="radio"/> Oncology - skull base to mid thigh <input type="radio"/> Oncology - top of head to toes <input type="radio"/> Oncology Brain <input type="radio"/> Neurology Brain <input type="radio"/> FDG <input type="radio"/> Amyvid CTA <input type="radio"/> COW-Brain <input type="radio"/> Carotids <input type="radio"/> Chest <input type="radio"/> PE Chest <input type="radio"/> ABD <input type="radio"/> Pelvis <input type="radio"/> Lower Extremity Run Off
MR Angiography <input type="radio"/> Head <input type="radio"/> Carotids <input type="radio"/> Chest <input type="radio"/> Abdomen <input type="radio"/> Pelvis <input type="radio"/> Other: _____ <input type="radio"/> Renal <input type="radio"/> Run Off <input type="radio"/> Upper Extremity <input type="radio"/> Lower Extremity <input type="radio"/> MRV		Ultrasound GENERAL <input type="radio"/> Thyroid <input type="radio"/> Abdomen Complete (Pancreas, Liver, GB, Spleen, Kidneys, IVC, Aorta) <input type="radio"/> RUQ (GB/Pancreas/Liver) <input type="radio"/> Kidney <input type="radio"/> Bladder pre & post void <input type="radio"/> Spleen (Left Upper Quadrant) <input type="radio"/> Pelvic w/Transvaginal (non-OB) <input type="radio"/> Scrotal <input type="radio"/> Soft Tissue VASCULAR <input type="radio"/> Aorta <input type="radio"/> Carotid Artery Duplex VENOUS DUPLEX (R/O DVT) Upper Extremity <input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Bilateral Lower Extremity <input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Bilateral	
X-Ray _____ _____		Arterial Duplex UPPER EXTREMITY <input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Bilateral LOWER EXTREMITY <input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Bilateral ABI <input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Bilateral TOS <input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Bilateral OTHER (SPECIFY) _____ _____	

STAR Imaging

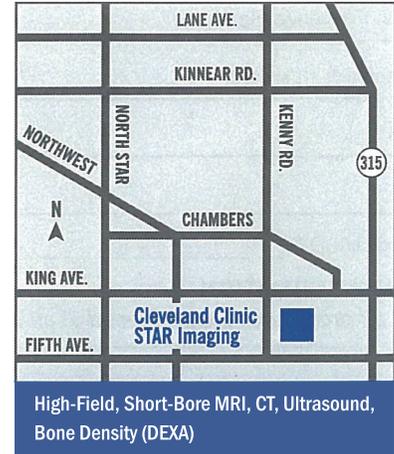
EXAM PREPS

Please call 614.358.4223. with questions prior to exam.

CT	<p>CT with Contrast No food or drink 4 hours prior. If contrast is required for your exam and you have a history of chronic kidney disease, diabetes mellitus, dehydration, congestive heart failure, multiple myeloma, kidney surgery, kidney neoplasm, recent chemotherapy or other nephrotoxic drugs or you are over age 60, recent BUN/creatinine lab work is required prior to your test.</p> <p>CT with No Contrast No prep</p>
PET/CT	<p>Please call 614.358.4223 for special instructions prior to exam.</p>
Nuclear Medicine	<p>Bone Scan, Brain SPECT, Resting MUGA, Liver/Spleen, Bone Marrow, Ceretec, WBC, Indium WBC, Hemangioma No prep</p> <p>Gall Bladder No food or drink 4 hours prior.</p> <p>Thyroid Scan No food or drink 4 hours prior. Must be off thyroid medication, iodinated multivitamin for six weeks unless instructed by physician, and no previous exams using iodinated contrast (i.e. CT contrast) for six weeks.</p> <p>Resting MUGA No prep</p> <p>Gastric Emptying Scan No food or drink 4 hours prior.</p> <p>Gallium* Renal exams (Captopril, Lasix, Non RPh)</p> <p>Prostascint* *IMPORTANT: Call 614.748-6100 and ask for Nuclear Medicine Department for proper prep</p>
Ultrasound	<p>Vascular No prep - Carotid, renal arterial, venous and ABI studies.</p> <p>Abdominal No food or drink 8 hours prior.</p> <p>Pelvic Drink 32 ounces of fluid to be completed 1 hour prior. Do not empty bladder.</p>
MRI	<p>If there is a history of metal shavings in eyes or metal in body, call 614.358.4223 to schedule screening.</p> <p>MRI Abdomen & MRCP No food or drink 4 hours prior.</p> <p>MRI with Contrast If contrast is required for your exam and you have a history of chronic kidney disease, diabetes mellitus, dehydration, congestive heart failure, multiple myeloma, kidney surgery, kidney neoplasm, recent chemotherapy or other nephrotoxic drugs or you are over age 60, recent BUN/creatinine lab work is required prior to your test.</p> <p>All Other MRI No prep</p>

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Columbus, Ohio 43212



921 Jasonway Ave., Suite A
Columbus, Ohio 43214



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