

HAWAII RADIOLOGIC ASSOCIATES, LTD.

IMAGING CENTER

HILO OFFICE:
 KINOOLE OFFICE:

670 Ponahawai St. #110
 1248 Kinoole St. #105

Hilo, HI 96720
 Hilo, HI 96720

Phone: (808) 933-2540
 Phone: (808) 935-7999

Fax: (808) 935-5207
 Fax: (808) 933-1227

(Patients) Last Name		First Name		Middle Initial		Date of Birth		Age		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Date of Exam	
(Guarantors) Last Name		First Name		Middle Initial		Known Allergies:						Appt Time	
Address						Date of Injury / Pregnancy (LMP)				Injury type: <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Other			
City		State		Zip		Description of Injury							
Home Phone:		Work Phone:		Stat Report <input type="checkbox"/> Phone Report <input type="checkbox"/> Fax Report		Fax Number: _____							
Primary Insurance:		Secondary Insurance:		Please check one: <input type="checkbox"/> Patient to Wait <input type="checkbox"/> Patient return with film and report <input type="checkbox"/> 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	CT & MRI EXAMS
UGI AIR CONTRAST W/SBFT	BONE AGE (SINGLE VIEW HAND)	OB COMPLETE	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: <input type="checkbox"/>
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	IV CONTRAST
CERVICAL COMPLETE	KNEE 2 VIEWS R L	SCROTUM	
CERVICAL SPINE COMP + FLEX/EXT	KNEE 3 VIEWS (ROUTINE) R L	BLADDER W/POST VOID RESIDUAL	

MRI EXAMINATIONS

HEAD	SPINE	JOINT / EXTREMITY (CONTINUED)	
BRAIN	CERVICAL SPINE	ANKLE	KIDNEY PROBLEMS? <input type="checkbox"/> YES <input type="checkbox"/> NO
BRAIN + MR ANGIOGRAPHY	THORACIC SPINE	FOOT	
CAROTID MR ANGIOGRAPHY	LUMBAR SPINE	SOFT TISSUE OR BONE MASS	
IAC	SPINE FOR METASTASES	ABDOMEN	
BRAIN - ATTN. POST. FOSSA	JOINT / EXTREMITY	ABDOMEN (GENERAL STUDY)	MISC
BRAIN FOR SEIZURES	SHOULDER	LIVER	SOFT TISSUE NECK
BRAIN FOR MULTIPLE SCLEROSIS	ARTHROGRAM SHOULDER	MR CHOLANGIOPANCREATOGRAPHY (MRCP)	BREAST ROUTINE
BRAIN FOR TUMOR/METASTASES	ELBOW	PANCREAS	BREAST FOR IMPLANTS
PITUITARY	WRIST	KIDNEYS	FEMALE PELVIS
ORBITS	ARTHROGRAM WRIST	RENAL MR ANGIOGRAPHY	BRACHIAL PLEXUS
	HIPS/PELVIC BONE	ADRENALS	
	KNEE		

HISTORY OF SURGERY	<input type="checkbox"/> NO <input type="checkbox"/> YES	DATE:	AREA:
COMPARISON STUDIES	<input type="checkbox"/> NO <input type="checkbox"/> YES If YES, Select: <input type="checkbox"/> MRI <input type="checkbox"/> CT <input type="checkbox"/> X-RAY <input type="checkbox"/> ULTRASOUND <input type="checkbox"/> NUCLEAR MEDICINE		

LOCATION AND DATE OF PREVIOUS STUDIES, IF KNOWN:

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

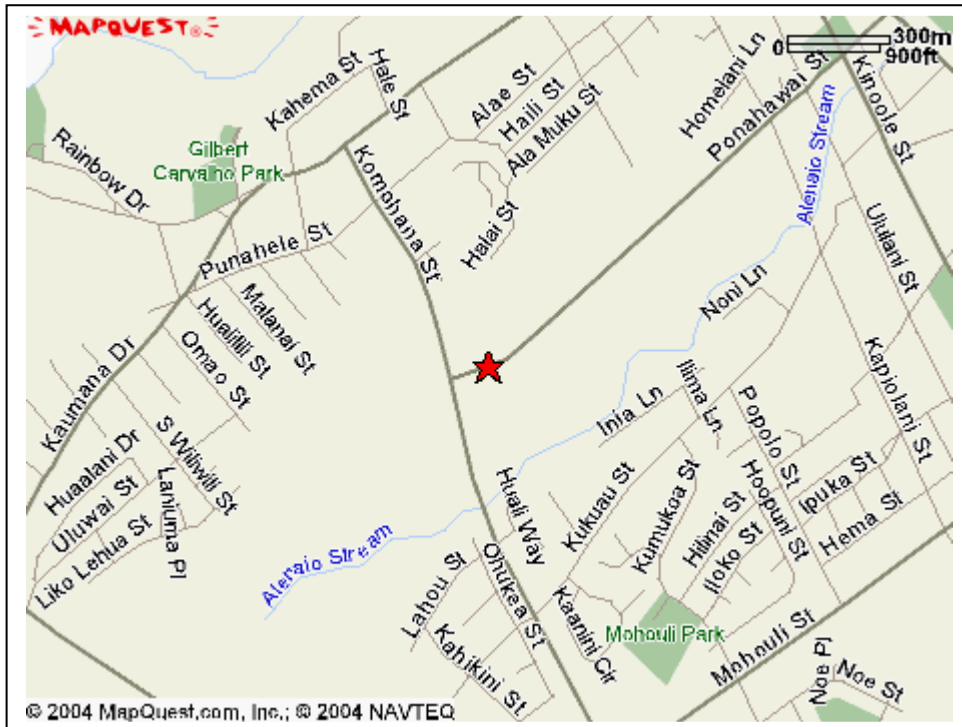
Signature of Patient or Patient's Representative

Date

Name of Patient's Representative:

Relationship to Patient:

Mailing Address of Patient or Patient's Representative:



SNF STAMP: