



ALFA DIAGNOSTIC

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PATIENT INFORMATION

NAME:		DIAGNOSIS			
DOB:					
TEL.:		SPECIAL INSTRUCTION:			
		Results	<input type="checkbox"/>	Routine	<input type="checkbox"/>
				STAT	<input type="checkbox"/>

LAB. GFR: CREATININE: BUN

REFERRING PHYSICIAN

NAME:	TEL.:	FAX:	SIGNATURE
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The patient has a "emergency medical condition" (EMC) as defined in Florida Motor Vehicle No-Fault Law, Florida Statutes Sections 627.730-627.7405

X-RAY				CT				MRI			
Walk in accepted Please call before arrival											
R		L		W/O		W		W/O		W	
<input type="checkbox"/>	Skull	<input type="checkbox"/>	Facial Bones	<input type="checkbox"/>	Head/Brain			<input type="checkbox"/>	Brain		
<input type="checkbox"/>	Orbit	<input type="checkbox"/>	Eyes	<input type="checkbox"/>	Pituitary/Sella			<input type="checkbox"/>	Brain (Seizure protocol)		
<input type="checkbox"/>	Nasal Bones	<input type="checkbox"/>	Sinus	<input type="checkbox"/>	Orbits			<input type="checkbox"/>	Brain (MS protocol)		
<input type="checkbox"/>	Sinus	<input type="checkbox"/>	Mandible	<input type="checkbox"/>	Temporal Bone/IAC			<input type="checkbox"/>	Pituitary/Sella		
<input type="checkbox"/>	TMJ	<input type="checkbox"/>	Soft Tissue Neck	<input type="checkbox"/>	Sinus			<input type="checkbox"/>	Orbits		
<input type="checkbox"/>	Cervical	<input type="checkbox"/>	Cervical	<input type="checkbox"/>	Maxillofacial			<input type="checkbox"/>	Temporal Bone/IAC		
<input type="checkbox"/>	Thoracic	<input type="checkbox"/>	Thoracic	<input type="checkbox"/>	Cervical			<input type="checkbox"/>	TMJ		
<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	TMJ	<input type="checkbox"/>	Thoracic			<input type="checkbox"/>	Sinus		
<input type="checkbox"/>	Scoliosis Series	<input type="checkbox"/>	Soft Tissue Neck	<input type="checkbox"/>	Lumbar			<input type="checkbox"/>	Maxillofacial		
<input type="checkbox"/>	Chest	<input type="checkbox"/>	Cervical	<input type="checkbox"/>	Neck soft tissue			<input type="checkbox"/>	Cervical Spine		
<input type="checkbox"/>	Ribs	<input type="checkbox"/>	Thoracic	<input type="checkbox"/>	Chest			<input type="checkbox"/>	Thoracic Spine		
<input type="checkbox"/>	Sternum	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Abdomen			<input type="checkbox"/>	Lumbar Spine		
<input type="checkbox"/>	Abdomen (KUB)	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Pelvis			<input type="checkbox"/>	Brachial Plexus		
<input type="checkbox"/>	Clavicle	<input type="checkbox"/>	Soft Tissue Neck	<input type="checkbox"/>	Abdomen & pelvis			<input type="checkbox"/>	Neck soft tissue		
<input type="checkbox"/>	AC Joint	<input type="checkbox"/>	Cervical	<input type="checkbox"/>	Kidney (Urogram)			<input type="checkbox"/>	Chest		
<input type="checkbox"/>	Shoulder	<input type="checkbox"/>	Thoracic	<input type="checkbox"/>	Liver (Triple phase)			<input type="checkbox"/>	Cardiac		
<input type="checkbox"/>	Scapula	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Enterography			<input type="checkbox"/>	Breast		
<input type="checkbox"/>	Arm	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Colongraphy			<input type="checkbox"/>	Breast (Implant)		
<input type="checkbox"/>	Elbow	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Upper Limb	W/O	W	<input type="checkbox"/>	Abdomen		
<input type="checkbox"/>	Forearm	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Humerus	R	L	<input type="checkbox"/>	Pelvis		
<input type="checkbox"/>	Wrist	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Forearm			<input type="checkbox"/>	Abdomen & pelvis		
<input type="checkbox"/>	Hand/Fingers	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Hand			<input type="checkbox"/>	MRCP (Cholangiogram)		
<input type="checkbox"/>	Pelvis	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Shoulder Joint			<input type="checkbox"/>	Kidney (Urogram)		
<input type="checkbox"/>	Hip	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Elbow Joint			<input type="checkbox"/>	Liver (triple phase)		
<input type="checkbox"/>	Sacrum / Coccyx	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Wrist Joint			<input type="checkbox"/>	Prostate		
<input type="checkbox"/>	SC Joints	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Lower Limb	W/O	W	<input type="checkbox"/>	Defecography		
<input type="checkbox"/>	Femur	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Femur	R	L	<input type="checkbox"/>	Abdomen		
<input type="checkbox"/>	Knee	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Lower Leg			<input type="checkbox"/>	Pelvis		
<input type="checkbox"/>	Tib / Fib	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Foot			<input type="checkbox"/>	Abdomen & pelvis		
<input type="checkbox"/>	Ankle	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Hip Joint			<input type="checkbox"/>	MRCP (Cholangiogram)		
<input type="checkbox"/>	Heel	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	knee Joint			<input type="checkbox"/>	Kidney (Urogram)		
<input type="checkbox"/>	Foot/Toes	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Ankle Joint			<input type="checkbox"/>	Liver (triple phase)		
<input type="checkbox"/>	Bone Age	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	CT ANGIOGRAPHY			<input type="checkbox"/>	Prostate		
<input type="checkbox"/>	Bone survey	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Head/Brain			<input type="checkbox"/>	Defecography		
<input type="checkbox"/>	Other	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Neck/Carotid			<input type="checkbox"/>	Abdomen		
<input type="checkbox"/>	3D MAMMOGRAPHY	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Chest/Aorta			<input type="checkbox"/>	Pelvis		
<input type="checkbox"/>	Screening	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Coronary Arteries			<input type="checkbox"/>	Renal		
<input type="checkbox"/>	Diagnostic	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Calcium score			<input type="checkbox"/>	Upper Extremity	R	L
<input type="checkbox"/>	Biopsy	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Abdomen			<input type="checkbox"/>	Lower Extremity	R	L
<input type="checkbox"/>	Other	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Pelvis			<input type="checkbox"/>	Runoff		
<input type="checkbox"/>	BONE DENSITY	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Renal			<input type="checkbox"/>	MR ANGIOGRAPHY		
<input type="checkbox"/>	Spine and Hip	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Upper Extremity	R	L	<input type="checkbox"/>	Head/Brain		
<input type="checkbox"/>	VASCULAR ULTRASOUND	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Lower Extremity	R	L	<input type="checkbox"/>	Neck/Carotid		
<input type="checkbox"/>	Carotid	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Runoff			<input type="checkbox"/>	Chest/Aorta		
<input type="checkbox"/>	UL Arterial	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Abdomen complete			<input type="checkbox"/>	Abdomen		
<input type="checkbox"/>	LE Arterial	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Abdomen Limited			<input type="checkbox"/>	Pelvis		
<input type="checkbox"/>	UL Venous	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Renal/Bladder			<input type="checkbox"/>	Renal		
<input type="checkbox"/>	LE Venous	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Pelvis			<input type="checkbox"/>	Upper Extremity	R	L
<input type="checkbox"/>	Ankle Brachial Index (ABI)	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Transabdominal			<input type="checkbox"/>	Lower Extremity	R	L
<input type="checkbox"/>	Renal artery	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Transvaginal			<input type="checkbox"/>	Runoff		
<input type="checkbox"/>	Aorta	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Transrectal			<input type="checkbox"/>	MR Venography		
<input type="checkbox"/>	Echo	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Soft Tissue neck			<input type="checkbox"/>	Head/Brain		
<input type="checkbox"/>	Other	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Thyroid			<input type="checkbox"/>	Neck		
<input type="checkbox"/>		<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Breast			<input type="checkbox"/>	Chest		
<input type="checkbox"/>		<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Testicular			<input type="checkbox"/>	Abdomen		
<input type="checkbox"/>		<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	Others			<input type="checkbox"/>	Pelvis		
<input type="checkbox"/>		<input type="checkbox"/>	Lumbar	<input type="checkbox"/>				<input type="checkbox"/>	Other		