DOCTORS CENTER
POLYCLINIC L.L.C

RADIOLOGY REQUEST FORM

+971 4 507 4600 Info@doctorscenterdxb.com www.doctorscenterdxb.com

Name:	Clinical Information:
D.O.B:	
Gender: ☐ Male ☐ Female	
Nationality:	
Referring Dr.:	
Phone No.:	
Email:	

MRI 3 Tesla

☐ With Contrast
☐ Without Contrast

☐ Brain
- ☐ Orbit
- ☐ Pituitary
- ☐ Facial
- ☐ MRS/DTI

☐ Neck
☐ Cardiac

☐ Cervical Spine
☐ Thoracic Spine
☐ Lumbar Spine
☐ Rectal
☐ TMG

☐ Abdomen (Liver, pancreas, kidney, adrenal, spleen)
☐ MRCP
☐ Enterography
☐ Pelvis
☐ Breast
☐ Prostate
☐ Other (Specify) _____

MR Angiography (Including Veins)

☐ Brain
- ☐ MRA
- ☐ MRV

☐ Neck
☐ Kidney
☐ Chest

☐ Upper Extremity ☐ Rt. ☐ Lt. _____
☐ Lower Extremity ☐ Rt. ☐ Lt. _____
☐ Other (Specify) _____

MR Musculoskeletal

☐ Cervical Spine				☐ Hip	☐ Rt.	☐ Lt.	
☐ Thoracic Spine				☐ Knee	☐ Rt.	☐ Lt.	
☐ Lumbar Spine				☐ Ankle	☐ Rt.	☐ Lt.	
☐ Sacroiliac	☐ Shoulder	☐ Rt.	☐ Lt.	☐ Foot	☐ Rt.	☐ Lt.	
	☐ Elbow	☐ Rt.	☐ Lt.	☐ Other (Specify) _____			
	☐ Wrist	☐ Rt.	☐ Lt.				
	☐ Hand	☐ Rt.	☐ Lt.				

CT Scan

☐ With Contrast
☐ Without Contrast

☐ Brain
☐ Paranasal Sinuses
☐ Temporal Bone
☐ Neck
☐ Calcium Score
☐ Cervical Spine
☐ Thoracic Spine
☐ Lumbar Spine

☐ Chest
☐ KUB
☐ Abdomen
☐ Abdomen & Pelvis
☐ Enterography
☐ Pelvis

☐ Upper Extremity ☐ Rt. ☐ Lt. _____
☐ Lower Extremity ☐ Rt. ☐ Lt. _____
☐ Other (Specify) _____

CT Angiography

☐ 3D Rendering

☐ Brain
☐ Neck
☐ Cardiac
☐ Pelvis

☐ Pulmonary
☐ Thoracic Aorta
☐ Abdomen

☐ Upper Extremity ☐ Rt. ☐ Lt. _____
☐ Lower Extremity ☐ Rt. ☐ Lt. _____
☐ Other (Specify) _____

Mammography

Digital Mammography

☐ Bilateral
☐ Tomosynthesis

☐ Unilateral

☐ Biopsy _____

Ultrasound

- ☐ Thyroid/Neck
- ☐ Breast
  - ☐ Unilateral
  - ☐ Bilateral
- ☐ KUB
- ☐ Abdomen
- ☐ Abdomen & Pelvis
- ☐ Pelvis
- ☐ Pelvis Transrectal
- ☐ Pelvis Transvaginal
- ☐ Prostate
- ☐ Scrotum
- ☐ Upper Extremity ☐ Rt. ☐ Lt. _____
- ☐ Lower Extremity ☐ Rt. ☐ Lt. _____
- ☐ Soft tissue _____
- ☐ Other (Specify) _____
- ☐ Biopsy _____

Obstetric

- ☐ 1st Trimester
- ☐ 2nd Trimester
- ☐ 3rd Trimester
- ☐ Other (Specify) _____

Doppler Ultrasound

- ☐ Carotid
- ☐ Liver
- ☐ Kidney
- ☐ Scrotum
- ☐ Penile
- ☐ Extermity Arterial (Upper) ☐ Rt. ☐ Lt.
- ☐ Extermity Arterial (Lower) ☐ Rt. ☐ Lt.
- ☐ Extermity Venous (Upper) ☐ Rt. ☐ Lt.
- ☐ Extermity Venous (Lower) ☐ ☐

Digital X-ray

Please Specify how many views:

_____

- ☐ Skull
- ☐ Nasal bone
- ☐ Sinuses
- ☐ TMJ
- ☐ Chest
- ☐ Ribs ☐ Rt. ☐ Lt.
- ☐ Sternum
- ☐ Clavicles ☐ Rt. ☐ Lt.
- ☐ Scapula ☐ Rt. ☐ Lt.
- ☐ Shoulder ☐ Rt. ☐ Lt.
- ☐ Arm ☐ Rt. ☐ Lt.
- ☐ Elbow ☐ Rt. ☐ Lt.
- ☐ Forearm ☐ Rt. ☐ Lt.
- ☐ Wrist ☐ Rt. ☐ Lt.
- ☐ Hand ☐ Rt. ☐ Lt.
- ☐ Finger ☐ Rt. ☐ Lt.
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine
- ☐ Sacrum
- ☐ Scoliosis
- ☐ Heel ☐ Rt. ☐ Lt.
- ☐ KUB
- ☐ Sacroiliac joints ☐ Rt. ☐ Lt.
- ☐ Pelvis
- ☐ Hip ☐ Rt. ☐ Lt.
- ☐ Femur ☐ Rt. ☐ Lt.
- ☐ Knee ☐ Rt. ☐ Lt.
- ☐ Tibia & Fibula ☐ Rt. ☐ Lt.
- ☐ Ankle ☐ Rt. ☐ Lt.
- ☐ Foot ☐ Rt. ☐ Lt.
- ☐ Toe ☐ Rt. ☐ Lt.
- ☐ Scanogram (leg length measurement)
- ☐ Others (Specify) _____

BMD

- ☐ Bone Densitometry (Specify) _____

Dental

- ☐ Panoramic
- ☐ Cephalogram
- ☐ CBCT
- ☐ TMJ

Others

- ☐ DLCO
- ☐ EEG
- ☐ ECG
- ☐ Spirometry

Specify: _____

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